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MEDICARE PAYMENTS FOR HOME HEALTH SERVICES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

PORTLAND, MAINE
NOVEMBER 16, 1987

Serial No. 100-15

Printed for the use of the Committee on Finance and the
Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
81-825 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-6
S361-37

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MEDICARE PAYMENTS FOR HOME HEALTH SERVICES

MONDAY, NOVEMBER 16, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON FINANCE, AND THE
SPECIAL COMMITTEE ON AGING,
Portland, ME.

The joint hearing was convened, pursuant to notice, at 10:04 a.m., in the City Council Chamber Room, Portland, Maine, the Honorable George J. Mitchell presiding.

Present: Senators Mitchell and Cohen.

[The press statement announcing the joint hearing and the prepared written statements of Senators Mitchell and Cohen follow:]

[Press Release of the Committee on Finance]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD FIELD HEARING IN PORTLAND, ME, ON MEDICARE PAYMENTS FOR HOME HEALTH SERVICES

WASHINGTON, D.C.—Senator George Mitchell (D., Maine), Chairman of the Senate Finance Subcommittee on Health, announced Monday that the Subcommittee will hold a field hearing in Portland, Maine on Medicare payments for home health services for the elderly. The hearing is a joint hearing of the Finance Subcommittee on Health and the Special Committee on Aging.

The hearing is scheduled for Monday, November 16, 1987, at 10:00 a.m., at the Portland City Hall.

"For more than a year, there has been a dramatic increase in Medicare reimbursement denials for home health care," Mitchell said. "We hope that this hearing will help us learn more about the cause of these denials and how we can best remedy this situation. We need to make certain that the quality of health care for our elderly is not affected."

OPENING STATEMENT OF SENATOR GEORGE J. MITCHELL

Good Morning. We are here today to examine the home health benefit under Medicare and to determine how well elderly patients are being served under current policies of the Health Care Financing Administration. As Chairman of the Senate Subcommittee on Health, this is a matter of deep concern to me.

I am pleased to be here today with my colleague with Senator Cohen, he is a member of the Senate Special Committee on Aging, who is also concerned.

The Medicare Home Health Benefit is a humane and cost-effective program which allows elderly persons to remain at home while receiving needed medical care. It is a program strongly supported by the elderly and their families and by the Congress.

Unfortunately, it is a program which has not been strongly supported by the Administration. In recent years, the Health Care Financing Administration has inititated a variety of policy changes that restrict home care benefits by means of increased claim denials and vague eligibility criteria.

Last year, the denial rate for Medicare home health care benefits in Maine reached 30%—the highest rate of denials in the nation. This dramatic increase in denials was and is a threat to the health care of Maine's elderly.

But this is not a problem limited to Maine.

Earlier this year, 26 Senators joined in sending a letter to the Secretary of Health and Human Services.

That letter expressed our concern about the rise in home care denial rates and requested that the Secretary account to Congress for the increase and report to Congress the changes HCFA plans to make in current policy to ensure that Medicare beneficiaries are receiving the home health services to which they are entitled.

The home health care benefit under Medicare currently makes up only 3% of the total Medicare budget. However, HCFA is concerned about the rapid growth of this program, and the increasing costs to the Medicare trust fund.

The growth of the home care benefit should be viewed as a positive development. The home care benefit is an expansion of the range of care available to Medicare beneficiaries, a development which gives greater choice to the elderly person and her family, and often is more cost-effective.

In April of this year I joined with Senator Bradley in introducing legislation intended to protect beneficiary access to the existing Medicare home health benefit, expand the benefit in a modest way, and protect the quality of care provided to the elderly by home health agencies.

I am pleased to report that the major provisions of the Medicare Home Health Services Improvement Act of 1987 were included in the Senate Finance Committee's Budget Reconciliation package and the Catastrophic Health Care legislation which recently passed the Senate.

We are optimistic that the Medicare Home Health Services Improvement Act of 1987 will improve access to the Medicare home health benefit under existing law—to allow elderly persons to continue to receive needed health care in their homes, where the great majority would prefer to stay.

I commend the Home Care Alliance of Maine for its dedication to the delivery of quality home health care to the elderly in our state. The cooperation and input from Maine's home health agencies was instrumental in the development of our legislation this year.

I look forward to the testimony to be presented by the scheduled witnesses today, and to comments from other interested persons later this morning.

I hope that we can continue to work together to protect and improve the home health care benefit for Medicare beneficiaries in Maine and across the nation.

Opening Statement of Senator William S. Cohen

Mr. Chairman, I commend you for your efforts to bring about this hearing on the administration of the Medicare home health benefit. I also thank you for making it possible for the Senate Special Committee on Aging to join forces with your Health Subcommittee in conducting the hearing.

The past few years have seen revolutionary change in our nation's health care delivery system. Soaring hospital costs have prompted dramatic changes in hospital utilization. Hospitals discharge patients earlier and doctors perform an increasing number of medical procedures on an outpatient basis. While not necessarily in need of the acute level of care provided by hospitals, many patients are sent home "sicker and quicker" and still in need of professional medical care.

Nursing home costs have also soared, becoming increasingly prohibitive for government, private insurers, and senior citizens alike. Therefore, it is evermore apparent that our nation's health policy must shift from its emphasis on institutional care to the development and utilization of a complete continuum of care. An essential component of this continuum is home health care.

Home health care is both a cost-effective and humane alternative to institutional care. Home health services, when delivered appropriately, can greatly improve the quality of life for the patient and often facilitate healing. Home care allows the patient to remain with family members in comfortable, familiar surroundings. For individuals living alone, home health services can be even more important, enabling them to maintain their independence and avoid institutionalization. Therefore, I am concerned by policies and practices that restrict the availabililty of home health care services when they are most needed as an alternative to the hospital or the nursing home.

A little more than a year ago, home health care providers in Maine saw a sudden and significant increase in the denial of claims for reimbursment under the Medicare program. This startling denial of reimbursement for services was not brought about by any change in Medicare laws or regulation, nor by any change in the manner in which the affected home health agencies submitted their claims. Since then, Maine's home health care agencies have struggled to comply with the new unwritten rules of the game amidst financial and administrative crisis. Elderly convalescents have gone without home health care services that previously would have been supported by the Medicare program. As we will no doubt hear this morning, beneficiaries and providers in other states are now also facing these same difficulties.

The Medicare prospective payment system, based on pre-determined reimbursement rates for specific diagnosis-related groups, gives providers every incentive to keep patients in the hospital only as long as is absoutely necessary. Since the implementation of this system, Medicare patients have been sent home from the hospital after shorter stays, and in greater need of follow-up health care than ever before. Clearly, it is incumbent upon Medicare to assure access to the level of home health care services made necessary by major cost-containment changes in the program. Policies which restrict access to home health care services drive medicare beneficiaries to more expensive treatment or deprive them of care which is crucial to their health and well-being.

It is indeed fortunate that Senator Mitchell has been such a champion of Medicare beneficiaries. Because of his efforts, and those of his staff, this hearing has a much more hopeful focus than it might have had. Earlier this year, Senator Mitchell, working with Senator Bradley of New Jersey, introduced legislation to clarify and expand the Medicare home health benefit. I am pleased to be a cosponsor of that legislation. Since then, Senator Mitchell has been successful in shaping both the Medicare catastrophic health care bill, which has passed the Senate, and upcoming budget reconciliation legislation so that these measures address the pressing problems in the administration of the Medicare home Health benefit. I applaud and support his efforts.

I look forward to the testimony of our witnesses this morning as they help us to understand the causes and implications of the Medicare home health denial problem, as well as the sufficiency of pending legislative remedies.

Senator MITCHELL. Good morning and welcome to this hearing. I have a brief opening statement, and Senator Cohen has a brief opening statement; and then we will begin to take testimony from the witnesses who have been invited to participate. At the podium is a sign-up sheet so that any member of the audience who is not a scheduled witness, but wishes to testify or to make comments, should go up at some time during the proceedings and just sign your name on that list.

Then, we will take that list and call on persons in the order that they signed up, if you want to make comments at the conclusion of the hearing. For the benefit of those who are standing, there is a balcony here in which there is room available. So, if there is anyone here who intends to stay for the hearing and would like to sit, you can go upstairs to the balcony if you would like.

We are here today to examine the home health benefit under Medicare and determine how well elderly patients are being served under current policies of the Health Care Financing Administration. As chairman of the Senate Subcommittee on Health, this has been and continues to be a matter of deep concern to me.

I am pleased to be here today with my colleague, Senator Cohen. He is a member of the Senate Special Committee on Aging and shares my concern. It is something we have discussed on previous occasions, and our discussions between ourselves and with others in Maine have led to this hearing.

The Medicare Home Health Benefit is a humane and cost-effective program which allows elderly persons to remain at home while receiving needed medical care. It is a program strongly supported by the elderly and their families and by the Congress. Unfortunately, it is a program which has not been strongly supported by the Administration.

In recent years, the Health Care Finance Administration has initiated a series of policy changes that restrict home care benefits by means of increased claim denials and vague eligibility criteria. Last year, the denial rate for Medicare home health care benefits in Maine reached 30 percent—the highest rate of denials in the nation.

This dramatic increase in denials was and is a threat to the health care of Maine's elderly; but this is not a problem limited to Maine.

Earlier this year, 26 Senators joined in sending a letter to the Secretary of Health and Human Services. That letter expressed our concern about the increase in the denial rates for home care and asked the Secretary to account to Congress for the increase and to report back to Congress on the changes that the Health Care Finance Administration plans to make in current policy to ensure that Medicare beneficiaries receive the home health services to which they are legally entitled.

The home health care benefit currently under Medicare makes up only 3 percent of the total Medicare budget. However, HCFA is concerned about the rapid growth of this program and the potential increase in cost to the Medicare Trust Fund; but I believe that the growth of the home health care benefits should be viewed positively.

That benefit is an expansion of the range of care available to Medicare beneficiaries, a development which gives greater choice to elderly persons and their families, and is often more cost effective.

In April of this year, I joined with Senator Bradley, Senator Cohen, and others in introducing legislation intended to protect beneficiary access to the existing Medicare home health benefit, expand the benefit in a modest way, and protect the quality of care provided by home health agencies. I am pleased to report that the major provisions of that bill—the Medicare Home Health Services Improvement Act of 1987—were included in the Senate Finance Committee's Budget Reconciliation package and the Catastrophic Health Care legislation recently passed by the Senate.

We are optimistic that this legislation will improve access to the Medicare home health benefit under existing law, to allow elderly persons to continue to receive needed health care in their home, where the great majority would prefer to stay.

I commend the Home Care Alliance of Maine for its dedication to the delivery of quality home health care for the elderly. The cooperation and input from Maine's home health agencies was instrumental in the development of the legislation I have just described.

I look forward to testimony to be presented by the scheduled witnesses today and to comments from any other person who is interested in expressing his or her view. I hope we can all continue to work together to protect and improve the home health care benefit for Medicare beneficiaries here in Maine and throughout the nation.

Now, I would like to call on my colleague, Senator Cohen, for his opening remarks.

Senator Cohen. Thank you, Senator Mitchell, and I would ask your permission to include my formal statement in the record, and perhaps I will just offer a few comments.

First, I want to commend Senator Mitchell for holding this hearing today. He really has been in the forefront of trying to deal with issues affecting our senior citizens. His efforts, along with those of Senator Bradley and others, have been responsible for forcing a direction that is very positive in the field of home health care.

Second, I would like to share a Chinese proverb that tells us that "man fools himself; he prays for a long life and yet he fears an old age." I think that what we are witnessing now perhaps explains the wisdom of at least part of that proverb. We have extended our life expectancy—we live longer—as a result of improvements in science and medicine; and yet, by virtue of that longer life, we are also experiencing greater health care needs. These increasing needs are putting tremendous financial pressure upon the individual citizen as well as upon our health care system.

And so, we find senior citizens in a fiscal and physical nightmare situation, in which they are not getting the care they need and cannot afford the care they deserve. Our hospitals are under tremendous pressures. Because of the soaring costs of medical services, hospitals are now discharging patients quicker; giving rise to the expression: "They are being discharged quicker but sicker."

Elderly patients must then be moved out of hospitals and back to their homes. Then we have a situation—an ironic situation—in which patients may be well enough to leave the hospital, or not sick enough to stay in the hospital, but they are too sick to be qualified for home health care.

It is an incredible irony that, should a Medicare patient convalescing at home be in need of acute care for longer than three weeks, he or she may be denied reimbursement for home health care altogether. So, these patients find themselves in what we would call a "no-care zone," in which they do not qualify for reimbursement in a hospital setting, but do not qualify for reimbursement for home health care either.

It has been suggested to me that perhaps the situation has improved. I did an interview just a few minutes ago in which one reporter said: "Hasn't the situation improved dramatically during the past year? Denials are down." The fact is that you can't simply look at the denial rate as being indicative of anything.

If the denials are down, it might just be because necessary services not being performed. Therefore, since the services are not being performed, the denial rates have dropped; and it might appear that all is right with the Medicare home health benefit.

So, I think that this hearing is going to be very productive for both Senator Mitchell and myself. We hope to find out more of the facts, to find out whether or not appropriate home health services are in fact being provided or denied, and whether we need to do more than what Senator Mitchell and others have already done—which is quite significant—in the recently passed Reconciliation and Catastrophic Illness bills.

I look forward to the hearing, Mr. Chairman, and I commend you again for your leadership on this.

Senator **Mitchell**. Thank you very much, Senator Cohen. The first panel of witnesses will include Dr. Charles Alexander of Ellsworth; Mrs. Noella Turcotte of Lewiston; and Ms. Christine Gianopoulos, Director of the Bureau of Maine's Elderly in Augusta. Would they all come forward, please, and take a seat up here?

Senator **Mitchell**. Thank you very much for coming, Doctor. Why don't we begin with your statement?

For the benefit of all the witnesses, under the rules of committee proceedings, we generally ask persons to submit written statements of any length and detail they desire, but to limit their oral remarks to five minutes each so that there can be ample time for questions; and other persons will have the opportunity to testify.

So, we will begin now with Dr. Alexander. Welcome, Doctor, please proceed.

STATEMENT OF DR. CHARLES ALEXANDER, M.D., ELLSWORTH, ME

Dr. **Alexander**. Thank you, Senator Mitchell and Senator Cohen, for the opportunity to address this hearing. As a prefacing remark, I am a physician in private practice in Hancock County, specializing in internal medicine and geriatrics. And I will say, from the outset, as a private practitioner, I only have second-hand knowledge of the logistics involved in Medicare reimbursements and denials of entitlement programs such as home care.

But I do have first-hand knowledge of the increasing needs of Maine's elderly for supportive services in the home, and my fear is that efforts to limit these services will strongly impact our ability to provide the needed care in the community. With this as a perspective, I would like to address two points.

First of all, I believe that the entitlements for home care, as they are currently listed under Medicare, are no longer adequate to meet the needs of today's elderly. And second, I feel that denial of Medicare benefits on the basis of medical necessity is hazardous and often unfair to patients.

The demographic facts of our aging population are familiar to you; and with aging, eventually comes increased disability. It is a fact that 70 percent of those patients over 85 require some supportive services to maintain their independence. This trend towards disability is occurring at a time when traditional medical care is becoming less available to the elderly. Through prospective payment and strict admission criteria, acute hospital care is no longer a viable option for many elderly with chronic disease.

At the other end of the spectrum, intermediate care facilities are less available. Because of these trends, community-based care is becoming increasingly necessary.

At this time, it would seem most appropriate to expand home-based care rather than to limit it. Unless we do this, we are going to provide a gap in needed medical care which will be created and will eventually affect a large portion of our Medicare population who are developing functional limitation and will do so in increasing fashion in the next few years.

Frequently, Medicare reimbursement is denied for home based services because entitled services are not provided. Entitled services, as you know, include skilled care to home bound patients on an intermittent basis. Technically, these denials enforce existing regulations and do not deny patients their entitled rights. However, I would argue that the entitlements, as they stand, which dealt very well with the acute care needs of patients in 1965, are no longer adequate to deal with the chronic care needs of the elderly in 1987.

They no longer deal with the real health care needs of the majority of today's Medicare recipients. Many elderly living in the community require intermediate care to maintain their independence. Many patients require home-based care even though they are not strictly home-bound, and many patients require ongoing care because their conditions are chronic. If we can't expand the entitlements to include some of these needs, we will eventually disenfranchise a segment of our elderly population.

I would offer as an example perhaps the hypothetical case of a patient with a compression fracture in a lumbar vertebra, which is a very common condition in osteoporotic elderly people. The treatment for this is bed rest and bed rest alone. Bed rest is not a criterion that will allow acute care hospitalization, and it is not a condition which requires skilled nursing care. It does require intermediate care, but intermediate care beds are not available on an acute basis or with short notice.

That type of person is frequently totally disenfranchised. What usually happens is that they are admitted to the hospital or to the nursing service at home and denied by the provider, so that the provider can protect their waiver of liability.

Another reason for Medicare denial of home care benefits is that entitled services are supplied but are ruled to be medically unnecessary. I believe that this practice denies patients services to which they are truly entitled.

It is hazardous to apply rigid guidelines when dealing with an inexact science and with individual patient needs.

Determination of medical necessity ought to be the responsibility of medical professionals who know the individual patient's condition, rather than that of nonprofessionals who are unfamiliar with the patient.

This issue is frequently reduced to meaningless word games. I have seen durable medical equipment and nursing services denied simply because the word "severe" did not appear in the patient's diagnosis. I have seen oxygen denied to a breathless, cyanotic woman with diffuse cancer spread in her lungs because a superfluous blood test was not performed, even though two doctors certified the need for oxygen.

Even when a series of home treatments is authorized, commonly the last several treatments will be denied. This type of hair-splitting involves professional judgment calls that can only be made with any fairness by the professionals who really know the individual patient.

One very valuable service that can be offered by home care nurses is a single visit home evaluation to determine whether some environmental reason for a patient's declined condition can be documented, yet single visits are universally denied unless skilled need is determined on that visit.

I, therefore, feel that with current denial trends, reviewers are in danger of usurping the right of health professionals to determine medically necessary treatments and prescribe for their patients.

In summary, I feel that the current frustration of care-givers is largely due to the fact that Medicare entitlements for home care are inadequate to deal with the actual needs of the patients. Current strict enforcement of guidelines only makes this deficiency more frustrating.

I also feel that the rights of health care professionals to determine medically necessary intervention is being eroded. I do recognize that it is difficult to reconcile the rapidly growing needs of our elderly with the need for cost constraint, but I do hope that these issues will be considered in future legislation. Thank you.

Senator MITCHELL. Thank you very much, Dr. Alexander. Ms. Gianopoulos?

STATEMENT OF CHRISTINE GIANOPOULOS, DIRECTOR, BUREAU OF MAINE'S ELDERLY, AUGUSTA, ME

Ms. GIANOPOULOS. My name is Christine Gianopoulos. I am the Director of the Bureau of Maine's Elderly in the Maine Department of Human Services. I appreciate this opportunity to comment on the impact of Medicare denials for home health care. My testimony is intended to put this issue into a broader context. To do so, I would like to address three areas.

First, the effect of home health care denial situations on Maine's elderly Medicare beneficiaries. Two, the need for legislative action to address the lack of a coherent national long-term care system. And three, the legislation currently under consideration by Congress.

Medicare home health coverage has the potential of providing comprehensive medical care for elderly and disabled individuals, but rigid interpretations of the regulations by the fiscal intermediary and HCFA have severely limited access to Medicare funded home health services. Providers are understandably unwilling to offer services for which they will not be paid, and elderly persons who once were served are now screened out.

The Home Care Alliance of Maine estimates a 25 percent decrease in the number of older people who were served last year. Elderly people who are not impaired enough or not poor enough to qualify for State or Medicaid funded in-home services programs have limited options. They may go without services, pay out of pocket, or exhaust their resources to a point where they are eligible for Medicaid.

Since only a minority of the elderly in Maine qualify for Medicaid, my concern is that many older people are simply going without care. Individuals who go without needed care run a greater risk of rehospitalization. This certainly cancels out any cost containment goals underlying HCFA's restrictive reimbursement policy.

Recent efforts have expanded access to in-home services for Maine's elderly population, but Maine's aging network has limited resources. In fact, admissions to both Maine's home-based care and elderly Medicaid waiver programs have been closed for months.

This limited capacity to respond may be reduced even further if Gramm-Rudman budget cuts affect Older Americans Act funds.

As the percentage of the population over 65 grows, demand for home health services has grown exponentially. In Maine, our Older Americans Act and State resources have been tapped to their limit. Already, other Older Americans Act mandates have been neglected in order to shift funding to support in-home services. The State of Maine cannot be expected to solve the problems caused by a Federal entitlement program which is supposedly available to virtually all elderly Americans. The Department of Human Services, in collaboration with the Maine Committee on Aging and legal services for the elderly, has developed an Advocacy for Medicare Patients Program. This program has been successful in reversing 65 percent of the 350 Medicare denials it has appealed.

Looked at another way, however, one might ask why we must allocate scarce public resources to generate Medicare reimbursement for services to which individuals were, in most cases, entitled in the first place.

Your focus today is on the effects of Medicare's restrictive reimbursement policy for home health care. As Director of the State unit on aging, my concerns about Medicare go beyond home health services. As a health care financing mechanism, Medicare covers 84 percent of hospital costs for the elderly. By contrast, it covers only two percent of chronic care costs and then only for short-term, post-acute episodes.

Many elderly persons have had no choice but to impoverish themselves in order to qualify for Medicaid-funded long-term care services. Medicare is the engine that drives the health care system for the elderly. While States have moved to redesign programs to respond to the need for supportive services, Medicare has remained firmly attached to an acute care institutional model. It has been said that, as a delivery system, Medicare is destined to best serve healthy forty year olds. This model may have made sense in 1965 when the number of individuals needing long-term care was smaller, but it is totally inappropriate today. We see that same institutional bias in the Medicaid program, but the popularity of Medicaid waiver programs is evidence of the desire by States to move away from an expensive institution model and toward a system that is often less costly and which encourages families to participate actively in the care of elderly relatives.

Given a national commitment to meet the needs of older citizens, there is no reason not to have a long-term care system that combines private, State, and Federal financing, gives older people choices, is State administered and locally managed, and is family-oriented.

The Medicare Catastrophic Protection Act currently before the Congress is a small step in the right direction, and we appreciate your support of this important legislation.

The inclusion of a prescription drug benefit will be of great assistance to older people whose medications are not covered by elderly drug programs and who are not eligible for Medicaid. Directing HCFA to apply a more reasonable standard to the definition of home-bound and intermittent care also should reduce the number of denials.

However, any attempt to fine tune a system that is fundamentally inadequate to the needs of a significant segment of the elderly population is only a short-term solution.

Addressing the Medicare denial issue is long overdue, but as a society, it is time we looked at how families and Government can collaborate to design a more appropriate long-term care system. Thank you.

Senator **Mitchell**. Thank you very much, Ms. Gianopoulos. Ms. Turcotte, welcome. I understand you have been involved in the home care problem. Why don't you just tell us in your own words what happened to you?

STATEMENT OF NOELLA TURCOTTE, LEWISTON, ME

Ms. **Turcotte**. It was after I had surgery, and I came home from the hospital after surgery, and the doctor told me I could go home, but I needed help at home. And I didn't want to go to a nursing home, so I came home.

At first, I had nurses come to change my dressing and everything; and I had a woman to clean the house and take care of things. And then after about a month, or maybe two months, I had a letter from Medicare saying that my claim was denied because I had an illness that was chronic, and I was responsible to pay the nurse from that day on.

So, I couldn't afford it. So, they were going to send me to a nursing home. And then the nurse stopped coming.

And then a couple of weeks later, my infection started again; and they had to take me back to the hospital. Then, the woman who was cleaning the house said: "You can't stand it any more. Let's call an ambulance." And I said, "No, I don't want to. I don't want to go to the hospital."

So, she called the office, and they told her to call the ambulance and take me to the hospital; and they had to operate as soon as I got there. I have no circulation in both my legs.

Senator **Mitchell**. When you went to the hospital that last time——

Ms. **Turcotte**. That was the second time.

Senator **Mitchell**. The second time? How long had you been without care at home before that?

Ms. **Turcotte**. For about two weeks.

Senator **Mitchell**. About two weeks?

Ms. **Turcotte**. Just two weeks. And then, I knew I had more problems, but I didn't know what was causing it. You know, I don't call the doctors because they don't come to your home.

Senator **Mitchell**. What did you do when you got the letter from Medicare telling you that they wouldn't cover you any more?

Ms. **Turcotte**. I didn't do anything. I didn't know what to do about it. So, all I am afraid of now is that now I will have to go to a nursing home. But when I went to the hospital, the infection was getting worse and worse; so, that is when they took me into the operating room. I have no circulation in both my legs.

Senator **Mitchell**. And you would prefer to stay home rather than go to a nursing home?

Ms. **Turcotte**. Yes.

Senator MITCHELL. Did you understand the letter that Medicare sent you?

Ms. TURCOTTE. No. I understand the denial, and I understood the part where they said I would be responsible from that day on, for paying the nurses.

Senator MITCHELL. Thank you very much, Ms. Turcotte. Senator Cohen?

Senator COHEN. Are you receiving home health care now?

Ms. TURCOTTE. Yes, I am.

Senator COHEN. And for how long a period of time have you been receiving that?

Ms. TURCOTTE. Since the last operation—the third operation—they have been coming. I don't know. They don't come now as much as they used to. I guess when Medicare stops paying—that is the way it works. When Medicare stops, the nurse stops coming.

Senator COHEN. How long do you estimate you have been home now from the second operation?

Ms. TURCOTTE. About two months now.

Senator COHEN. So, you have been receiving care?

Ms. TURCOTTE. Yes. They used to come once a day, then three times a week, and then twice a week; and now, they come once a week.

Senator COHEN. So, we have a situation in which Medicare originally denied the visits at home?

Ms. TURCOTTE. Yes.

Senator COHEN. And now, after you have gone back in for another operation——

Ms. TURCOTTE. Yes, they started paying again when I got home, but they pay so long and then they stop. They don't pay enough; I know because the nurse stops coming.

Senator MITCHELL. Dr. Alexander, you discussed what you really see as two problems. One is that you believe that the coverage under the law to perform services is inadequate. Now, that is not a problem for the fiscal intermediary; that is a problem for Congress and the President to resolve.

You believe that the extent of the coverage—the reimbursement under Medicare home health care—is inadequate in its scope. You recognize that that is a problem of the fiscal constraint that we are under?

Dr. ALEXANDER. Correct.

Senator MITCHELL. Beyond that, with respect to the area that you believe to be covered, there have been—as you described it—unreasonable denials made. And you focused on the question of medical necessity. You pointed out that the judgment of physicians, such as yourself, is being repudiated by persons who are not physicians who are employees of the fiscal intermediaries. Do I understand that to be one aspect of your criticism?

Dr. ALEXANDER. Correct.

Senator MITCHELL. Right. The legislation that we have been involved in—Senator Cohen and myself and others—would require a review process or a denial made on the basis of medical necessity to be made by a physician. Do you believe that would at least be helpful?

Dr. ALEXANDER. Yes.

Senator **Mitchell**. I want to get one point across. I don't think you are urging that the judgment of the attending physician be absolutely controlling for reimbursement purposes without any review whatsoever. These are public funds. We have to respond to taxpayers' concerns—legitimate concerns.

Do you believe it would be appropriate if the judgment of the attending physician were reviewed by another physician as opposed to a nonphysician?

Dr. **Alexander**. Yes. I think that would be very constructive. I think that the guidelines that exist for this now are rigid and they have to be; all the guidelines have to be rigid, but they are being applied to a very unrigid system. It takes medical knowledge to put the proper flexibility into that review process.

Senator **Mitchell**. All right. Would you provide Senator Cohen and me in writing at your convenience your analysis of the first part of the problem in somewhat more detail? That is, those services under home care that are not now covered under the law that you believe should be covered, so that we can have the benefit of your knowledge?

Dr. **Alexander**. Certainly.

Senator **Mitchell**. Now, that is not the scope of this hearing, but it would be very helpful to us because it is all part of one problem.

Dr. **Alexander**. Right.

[The prepared information follows:]

[Information not received at press time.]

Senator **Mitchell**. Thank you. Senator Cohen?

Senator **Cohen**. I have just a couple questions. Picking up on what Senator Mitchell was saying, what is your impression of how the DRGs have been implemented in the health care system? Is the DRG schedule too rigid? I think the words you used were "hazardous to deny" the physicians, who are responsible, the prerogative to make these determinations on health care, but don't we do that with DRGs right now?

Dr. **Alexander**. The DRGs themselves are quite rigid. I think in the case of denial of benefits, because there is professional review at the end of the process, it frequently turns out that there are fair reversals of some of those decisions. And I think that physician review in this case would help as well.

Senator **Cohen**. We recently had a hearing before the Senate Special Committee on Aging. One of the subjects that came up was that physicians are providing more and more services for fear of liability—lawsuits. If the determination as to which health care services Medicare should or should not provide were left entirely to physicans, would not doctors always err on the side of giving more care, rather than holding back as a fiscal intermediary might?

Dr. **Alexander**. Yes. I definitely think the fiscal intermediaries should have an input in this because of not only liability reasons, but for patient comfort and for patient medications. There is no restraint to provide more services than less.

Senator **Cohen**. I guess I have a final point. You mentioned the word "rehospitalization." What has been your experience in terms of the denial of home health care coverage and the rehospitalization of those patients?

Dr. **Alexander**. I have not had very much experience with that. We have a high rate of rehospitalization among our elderly, anyway; but I am not sure I could come up with specific examples of where that was directly due to Medicare denying home services.

Senator **COHEN**. We saw Mrs. Turcotte's case.

Dr. **ALEXANDER**. Absolutely. Yes.

Senator **COHEN**. Thank you very much.

Senator **MITCHELL**. Ms. Gianopoulos, let me ask you just one question. If your testimony, you said that the Department of Human Services in collaboration with the Maine Committee on Aging and Legal Services for the Elderly has been successful in reversing 65 percent of the 350 Medicare denials it has appealed. Do you have any way of estimating the cost of appealing those denials?

Ms. **GIANOPOULOS**. No, I don't, but I think someone--the director of that project—will be testifying this morning; and he can probably give you an estimate.

Senator **MITCHELL**. All right.

Ms. **GIANOPOULOS**. I know the budget for that program is approximately $45,000 a year.

Senator **MITCHELL**. The budget?

Ms. **GIANOPOULOS**. Advocacy for Medicare patients, that project.

Senator **MITCHELL**. All right.

Ms. **GIANOPOULOS**. And we are recovering far in excess of that.

Senator **MITCHELL**. Yes. Thank you all very much for coming. It has been very helpful and informative. Thank you, Ms. Turcotte.

We will now hear from the next panel which includes Louise Gamache, Clinical Director of Kno-Wal-Lin Community Health Services in Rockland; Joseph Pickering, Chairman of the Home Care Alliance of Maine, and Executive Director of Community Health and Counseling Services of Bangor; and Linda Billows, Regional Director of the National Association for Homecare, Visiting Nurses Association of Greater Salem, Salem, Massachusetts.

Good morning. Thank you all for coming. We will begin with Ms. Gamache.

STATEMENT OF LOUISE S. GAMACHE, CLINICAL DIRECTOR, KNO-WAL-LIN COMMUNITY HEALTH SERVICES, ROCKLAND, ME

Ms. **GAMACHE**. On behalf of the Home Care Alliance of Maine, I want to thank you, Senator Mitchell and Senator Cohen, for holding this joint subcommittee hearing on Medicare coverage of home health services. There have been several results regarding HCFA that you have heard about this morning. The overall Medicare caseload in Maine has dropped an estimated 25 percent in one year.

Home health providers have suffered financial distress. Hospital discharge planners and physicians are uncertain in making referrals to home health agencies because of the confusion. And last, and most important, elderly patients have seen their access to home health care reduced and their benefits curtailed.

As we have attempted to deal with this problem in Maine, we have been repeatedly frustrated in our attempts to learn the revised rules and interpretations of Medicare reimbursement which we believe are and remain unwritten. We have developed three goals in battling the crisis of high denial rates.

First, we insist upon proper disclosure of all rules, regulations, guidelines, and instructions affecting home care.

Second, we insist upon prospective, rather than retrospective, application of all new and revised reimbursement rules. And finally, we seek to avoid reductions in current rights and benefits of Medicare beneficiaries.

The Home Care Alliance of Maine has come to one clear realization. We will only get relief through the courts and through Congress. For that reason, we turned to the Maine Congressional Delegation for help, and you have responded to our concerns, Senator Mitchell, by sponsoring legislation.

We have analyzed both your bill, Senate 1076, and other pending bills; and our opinion is that the following legislative provisions taken together, as they will be in the reconciliation process, will ameliorate the problem of artificially high denial rates. I will express a preference for the version which best accomplishes the goals previously expressed.

First, the Senate version of the catastrophic bill provides clarification of the requirement that a patient requires skilled care on an intermittent basis. The new definition would provide that daily skilled nursing visits can be up to seven days a week, with one or more visits per day, for a period of up to 21 days. Further, beneficiaries could receive up to 45 days of daily care within 30 days of discharge from a hospital or skilled nursing facility.

While we would prefer that the discharge requirement be dropped and the number of allowable days of care increased, we recognize that budget constraints may be a factor.

Second, Medicare law presently requires that an individual be homebound to be eligible for home health services. The Senate version of the catastrophic bill specifies that an individual need not be bedridden, as HCFA has interpreted, but instead be confined to home because of a condition which restricts departure with assistance.

Third, we favor a combination of House and Senate provisions that would streamline the appeals procedure for home health benefits: (a) Fiscal intermediaries should be required to provide a full explanation of all denials for home health services; (b) all parties should be given prompt notification of decisions; (c) the Secretary of HHS should be required to take into account the advisability to process 75 percent of reconsiderations within 60 days; and (d) the Department of HHS should pay two percent interest if an FI fails to notify the provider of its decision after 60 days.

Fourth, all home health regulations, instructions, clarifications, interpretations, and screens for medical review should be published in the Federal Register. It is our view that the Department of Health and Human Services circumvents the Administrative Procedure Act.

We also express caution that sometimes the slow tortuous process of publication of the Federal Register can delay implementation of rules, which may require faster action.

Fifth, we are opposed to the control of the Administrative Law Judges by HCFA for the purpose of Medicare appeals, and we are also opposed to telephone hearings. We believe either of these proposals would be detrimental to the due process rights of Medicare beneficiaries.

Sixth, we oppose the provision in the House catastrophic legislation which would transfer home health care benefits from Part A to Part B of the Medicare Program. We believe such a provision would be harmful to beneficiaries because Part B is not an entitlement program as is Part A, that copayments are a requirement under Part B, and that the appeals process under Part B is lengthier than under Part A.

Seventh, we understand that the Senate Finance Committee adopted an amendment to have a geriatrician review claims denied for lack of medical necessity. We think this is a step in the right direction. The term "medical necessity" is undefined in Medicare law and is being used in an arbitrary manner to deny claims.

Eighth, we applaud the provision in the Senate reconciliation bill that would prohibit the Secretary of Health and Human Services from using quotas in the medical review function as they have done in the past. This practice should be condemned because it has no bearing upon the medical needs of beneficiaries.

And finally, we urge great caution in the study and eventual implementation of a prospective reimbursement system for home health services. We strongly believe that a permanent basis for payment is unwise and ill-founded. The fiscal intermediaries would still control denials, conduct medical review, and the onerous documentation requirements would not be diminished. We would much prefer a prospective payment system structured on a per-case basis. We think it would result in appropriate patient care and cost savings for the Medicare Program.

The elderly are the victims of this crisis of Medicare denials. In the wake of reduced accessibility to acute care, home health care is truly the last resort for Medicare beneficiaries. We do not feel that the elderly should be forced to bear a disproportionate share of the current cost cutting, whether that cost cutting is directed by Congress or is accomplished indirectly through administrative means.

The Home Care Alliance of Maine believes these legislative provisions will go a long way in alleviating the current crisis. We hope you and your colleagues in Congress will be diligent in reviewing the effects of Congressionally enacted changes and in monitoring the performance of the Executive Branch in the coming months and will make use of the investigatory power of the GAO for accurate determination of that performance.

In closing, the Home Care Alliance of Maine wants to commend you, Senator Mitchell, for holding this hearing and for sponsoring legislation. We also salute your authorship of a recent amendment to provide coverage for home intravenous drug therapy. We think that, if approved by both Houses of Congress, this proposal will help Medicare beneficiaries receive care in a less restrictive, less expensive setting.

We also want to thank Senator Cohen for his cosponsorship of the Mitchell legislation and for his efforts along with those of Congressman Brennan and Congresswoman Snowe in uniting the Maine Congressional Delegation against the harmful increase in denials of home health services.

Senator MITCHELL. Thank you very much, Ms. Gamache. Mr. Pickering?

STATEMENT OF JOSEPH H. PICKERING, JR., CHAIRMAN, HOME CARE ALLIANCE OF MAINE, AND EXECUTIVE DIRECTOR, COMMUNITY HEALTH AND COUNSELING SERVICES, BANGOR, ME

Mr. PICKERING. Thank you for the opportunity to speak. Senator Cohen, you started with a Chinese proverb, and I will give you another one. "The journey of 1,000 miles begins with the first step," and thanks for helping us move along that journey. We have got a long ways to go, but your contributions have been very important.

I am Chairman of the Medicare Task Force of the Home Care Alliance of Maine and Executive Director of Community Health and Counseling Services. I am testifying on the impact of the Medicare denial crisis and other ill-considered HCFA initiatives have had on our beneficiaries in Eastern Maine.

The service area of Community Health and Counseling Services—CHCS, for short—is huge, slightly smaller than the combined land area of Massachusetts and Connecticut. Bangor headquarters are located in a standard metropolitan area. CHCS is therefore classified as urban, although 70 percent of our patients live in rural areas, which range from medium-size towns to very isolated rural areas.

Although the size of the service area and the diversity of the geographic and demographic characteristics are unusual, I believe that this diversity will allow you to universalize our experience.

Much has been said about the current crisis in home health on the national level by beneficiary and provider representatives. While such national input is informative and necessary for the formation of national health policy, these statistical averages disguise the true human impact on beneficiaries, their care-givers, and those agencies that are licensed to provide home care.

The lack of services to a person in Eastern Maine who used to be eligible for care cannot be statistically averaged with a person in another region who may be receiving all the care they need. A national denial rate of six or seven percent, while shocking to those who understand the industry, does not begin to tell the story of sheer human misery caused by denial rates of one in four or one in three in some areas of the country.

Some microstatistics will illustrate the impact on real people in Maine. They should shock even those policy-makers in HCFA who have been the key cause of this crisis. In 1986, CHCS made 35,700 visits, of which 20,700 were to Medicare patients. This was the year before the denial crisis hit Maine. In 1987, CHCS delivered 30,500 visits, of which only 13,700 were to Medicare patients. This means that Medicare visits declined by 7,000 in a single year.

Thirty-four percent fewer visits were delivered to Medicare beneficiaries than were delivered in 1986. This situation would be serious enough if nothing else were going on, but there are other pressures on home care to increase rather than decrease services. The average length of stay in hospitals has shortened—the "sicker and quicker" discharge phenomenon—and the general population continues to age.

When these factors are coupled with the insufficiency of nursing home beds, what happened to the Medicare population who received 7,000 fewer visits in 1987? Did their conditions deteriorate to the point where expensive rehospitalization was needed? Did they hang on long enough, in a lower than necessary functional state, until they were able to get permanent nursing home beds? Or did they simply and disgracefully just die sooner because they could access the care they needed and were entitled to on a timely basis?

We have no way of knowing what actually happened to the Medicare beneficiaries, these victims of HCFA's short sighted and Congressionally unauthorized policies, such as NCFA's redefinition of homebound, medically necessary, etcetera. We can clearly draw some inferences of the impact from the demographics of our patient population. By definition, the vast proportion of our Medicare patients are elderly. In fact, 77 percent are over 70 and 37 percent are 80 years of age.

What is the living situation of this population? Of a total of 894 Medicare patients. 28 percent live alone, while 37 percent live with their spouses. Of those remaining, a portion are classified as living in elderly housing, which means alone or with a spouse. Our average Medicare patient has very little income; 26 percent earn less than $5,000; 74 percent have incomes less than $10,000. These figures are average household incomes, not personal incomes of the individual Medicare recipients.

Given the statistics you have just heard and given the decrease in hospital admissions and the shortening of the length of stay, HCFA is requiring the frail elderly to provide a level of care for their spouses which was provided in an acute care hospital only a few years ago. In effect, we are asking an 82-year-old to provide a level of care to their 85-year-old spouse that, prior to 1986, was provided by a hospital, and prior to 1987 was provided by our home health agency.

I don't know whether so-called primitive peoples ever really abandoned their elderly to certain death, but what are we doing as a nation when we ask the frail elderly to provide extensive care to the frail elderly? How often has the health of one spouse been destroyed while trying to provide care for the other?

You would be entirely justified in asking what CHCS is doing to provide home health care to those who really need it.

Last year, even with our decreased service units, my agency's home health program lost over $77,000. CHCS is a private, nonprofit agency, and I do my best to make sure that we run on an efficient, business-like basis. We risk bankruptcy with deficits like this and can surely not continue to lose money on this scale. The situation of other home health agencies in Maine and around the country is unfortunately all too similar. We are putting our survival as agencies on the line to deliver as much as we can to those who need it.

What can Congress do to alleviate the current situation? Louise has given an excellent presentation. I think one of the things is that Congress can ensure that the services it originally intended to be available to the frail elderly are in fact available and have not been diluted by the unelected policy-makers within HCFA. I thank you both for initiating and supporting legislation which addresses many of these problems. You have done a great service to the frail elderly of our country, but isn't it a sad day in the life of our country when we need to pass new legislation in order to force a government agency to pay for services that were clearly voted by Congress 20 years ago?

My written testimony provides information from CHCS and other agencies in Maine, detailing the effects of HCFA's policies. Given the limited time, I thought that the beneficiaries deserved prime billing in the oral testimony.

However, this medigate situation has taken a real terrible toll on home health providers. Only Br'er Rabbit and a Federal bureaucrat could love the thicket of regulations that we have to run through. I would like to embody this in a poem, which conveys the feeling:

> We are a storm-tossed little lifeboat on a Blue Cross—HCFA sea; Rescuing some frail elderly from giant waves of bureaucracy. We save as many as we can, but our boat is small and far from land. How many disappear in darkened waters, never, never to be seen again? When will this typhoon of madness end?

Thank you.

Senator MITCHELL. Thank you, Mr. Pickering. Ms. Billows, welcome.

STATEMENT OF LINDA BILLOWS, REGIONAL DIRECTOR, NATIONAL ASSOCIATION FOR HOMECARE, VISITING NURSES ASSOCIATION OF GREATER SALEM, SALEM, MA

Ms. BILLOWS. Good morning, Senator Mitchell and Senator Cohen. I am Linda Billows, Region I Director for the National Association for Homecare, and I represent the New England States. I, too, would like to thank you for holding this hearing this morning so that we can share with you our grave concerns regarding the Medicare denial crisis in Region I.

I would also like to thank you for your legislative efforts in terms of clarifying the Medicare homecare benefits.

My testimony this morning will focus on the regional impact of this crisis. Currently there are 305 certified home health agencies in Region I who bill Blue Cross of Maine for their Medicare homecare patients. The nature of the problems being experienced include a high denial rate, coupled with the fact that the denials appear to be arbitrary and capricious, delays in reopenings and reconsiderations.

Inadequate staff at Blue Cross of Maine, both in terms of number, training, and performance. The problems with medical necessity denials is our greatest concern. The denial crisis is devastating—devastating to patients, staff of the home health agencies, and the agencies themselves.

The crisis is not just a few agencies, nor any one State. Agencies, State Associations, and the National Association for Homecare have collected data to substantiate the severity of the problem. The data I share with you this morning have been submitted to the National Association to quantify the avalanche of denials and the chilling effect on agencies.

From Maine, an 86-year-old man who was admitted to a home health agency after surgery for a bowel obstruction. The initial order from the physician included a nursing visit every day to change an eight-inch incision on the patient's abdomen. At the time of the admission, it was noted that the patient was extremely weak, was experiencing abdominal pain, and was short of breath and spending most of his time in bed. Additionally, the patient's spouse suffered from Alzheimer's Disease. Blue Cross of Maine denied all but two visits.

From Vermont, a woman admitted to post-hospital stay for chronic obstructive pulmonary disease and congestive heart failure. Skilled nursing visits once a week were felt to be appropriate to monitor the patient's respiratory and cardiac status. The patient required teaching in how to use her inhalator and oxygen, and she needed instruction in her medication, as well as being extremely weak and short of breath. The certification period submitted to Blue Cross of Maine was May 7 through July 7, 1987.

There was an arbitrary decision by Blue Cross of Maine to deny four out of seven visits. The patient expired on June 21, 1987.

I would also like to share with you some letters from agencies that support the chilling effect that they are experiencing because of the denials, and I quote:

> Maine agencies were the first to feel the effect of the transfer in July of 1986 to Blue Cross of Maine. The following information is compiled from the four largest agencies in Maine, who have completed their first fiscal year, under the new regime. During July through September 1986, Maine agencies who had never been off of waiver were hit with an onslaught of denials, and denial rates rose to 25 percent.
>
> It accelerated through the October to December period, ending with a denial rate topping 37 percent. The extraordinary denials were compounded by dramatic cutbacks in Medicare service delivery.

And I am still quoting from the Maine agencies:

> A decrease in Medicare visits of 26 percent, a decrease in Medicare patients served by 16 percent, a decrease in Medicare visits per patient by 11.9 percent, an average increase in cost per visit of 12 percent."

From Massachusetts:

> The impact of the Medicare denials on our patients and on our agencies has been substantial. Prior to 1984, our agency was providing 47,000 visits per year. We are now providing 27,000. I believe the loss of these visits is the increase in the Medicare denial system and the fear of it. We find staff who fear providing service because of their concern for denials and a grave concern on the part of our patients as they receive a denial letter from Blue Cross of Maine.
>
> In the current months of July and August, our denials are running $5,000 to $7,000 per month. In a private nonprofit agency with little surplus, you can see that without a turnaround in the system, we will be out of business in a very short period of time. The threat of bankruptcy remains ever present. If an agency provides care in good faith in accordance with regulation and then is retroactively denied, who could tolerate this loss on an ongoing basis?
>
> It is completely unpredictable. Give us the rules, please, so that we can follow them. The denials are subjective and irrational.

In May of 1985, the home health agencies in Region I began meeting on a regional basis prior to our transfer to Blue Cross of Maine because of our concern with the possible ramifications of this transfer. The goal of our group, which by the way has been meeting for 31 months, was to maximize communication with Blue Cross of Maine. It was our intent to establish regular meetings with the intermediaries so that the issues could be discussed in advance of their becoming problems.

We have met more than a dozen times as a regional group with Blue Cross of Maine. Health Care Financing Administration representatives have been present at a majority of these meetings. In reviewing the minutes of the meetings of the past 31 months, I found the problems had not changed. They continue to be the denials, the delay in reopenings, the lack of timely issuance of pro-policy clarification, and inadequate staffing, as well as training and performance.

We have also had difficulties with the waiver of liability calculation.

In closing, I would like to thank you on behalf of the elders we serve and the agencies I represent. Agencies in Region I cannot continue to weather the onslaught of the Medicare denial storm. Clients are not getting Medicare coverage for visits, to which they are entitled. Agencies are continuing to provide service, while watching their deficits grow.

It would be a cruel irony of life if agencies go out of business while trying to advocate on behalf of the clients they serve. Who then will provide the home health care in New England? Thank you.

Senator MITCHELL. Thank you very much.

In your statement, Ms. Billows, you said that denials seem arbitrary and capricious. Are you unable to assign any classification or categorization or rationalization of denials? Do they seem to you to be just completely arbitrary and capricious, unrelated to the severity of the condition of the beneficiary or any other factor?

Ms. BILLOWS. I will go back to one of the examples I used: a woman who had chronic obstructive pulmonary disease, and had the same treatment on seven visits, with relatively the same need on those seven visits, yet three of those were paid for and four of those were denied. So, not only does the agency not know which of the four were denied and which three were paid for, but it has a difficult time determining what the difference was during that course of care that the patient received.

Senator MITCHELL. Do you, Ms. Gamache, and you, Mr. Pickering, agree that there is no basis in your experience for defining or classifying or rationalizing in any way the denials that have been made?

Ms. GAMACHE. The medical necessity definition is undefined under the law, and the same sort of hatchet job occurs in Maine. If we have daily visits, they say three times a week will be enough; and they can't point to which of the visits are denied on the basis of anything within the regulations. They just think that is enough, and it is very difficult to deal with that sort of thing and apply that sort of behavior to the next patient. How do you measure how that will affect the next time they make a decision on patient care.

So, we are really at a loss as to how to treat patients, other than what we feel, in our professional judgment, should be done to care for people properly.

Senator MITCHELL. Mr. Pickering? Do you agree with that?

Mr. PICKERING. Yes.

Senator MITCHELL. Let me ask the three of you whether you believe this problem to be, at least in part, created by a transition and already on the way to resolution? In other words, have you seen any improvement in the last few weeks or recent months? We will begin with you, Ms. Billows.

Ms. BILLOWS. I understand that, back in August of this summer, there was a quality assurance program instituted at Blue Cross of Maine. I guess what our question has been during our course of over a year meeting with Blue Cross of Maine is that, clearly in order to get consistency among the people reviewing the claims, there must be some written guidelines that those reviewers are using.

I think if those guidelines could be shared with providers, then in fact we would understand what is covered and what is not. You know, we are not sure whether those guidelines either do not exist or we don't have access to them. But in order to assure consistency among our reviewers, there must be something written, we would think.

Senator MITCHELL. Yes. Ms. Gamache, have you seen any improvement in recent weeks or the past several months?

Ms. GAMACHE. We have had a reduction in denials. We have also had a great reduction in our universe of patients. We have staff who have been under this pressure for a year and who have modified their behavior to the point that they are hesitant to give the patient more visits or even admit patients. The discharge people for hospitals and physicians are very wary about homecare. They used to understand the program; now, there is great confusion.

So, we may not even be getting the referrals in order to make a judgment on whether a patient should receive care or not. We are very concerned about that missing population that we are not even able to assess and bring into the system, if it is appropriate.

Senator MITCHELL. Mr. Pickering.

Mr. PICKERING. Our experience has been similar, too. There has been a lull or a slowdown in the number of denials in the past few months, but I think there are some factors stopping it. I think that we are not better trained; I think that we are better adept at trying to figure out how to defeat Blue Cross of Maine and HCFA in its patient roulette games. That has been our experience. In our caseloads, we are now seeing Medicare providing more services, but it is nowhere near what we were providing a year ago.

Senator MITCHELL. But for whatever reason, what you are telling me is that there has been some decline in the rate of denials in recent weeks or months?

Mr. PICKERING. Right.

Ms. BILLOWS. May I just comment, too, in addition? Over the course of the past year when we have seen additional agencies transfer onto Blue Cross of Maine, there has been a slowdown in terms of the claims review from the other States. Ninety-three agencies from Connecticut transferred July of this year; so, that was a great increase in number of claims that they were reviewing. So, our experience has been that that has always resulted in somewhat of a slowdown for the other agencies.

Senator MITCHELL. Yes.

Mr. PICKERING. What hasn't slowed down is the paperwork. We have documented in our written testimony—and I won't go into it now—just what it is costing us, you know $1.00 and $2.00 per units of service, just to document and meet all the regulatory requirements. We have a very sophisticated accounting/fiscal system. So, we put that in the written testimony. You know, as a taxpayer, it is just simply ridiculous to have us—you know, on the one hand, we have got a Federal deficit. All right. One way we can deal with the Federal deficit is to take a hard look at what it is costing home health agencies and others to comply with all these regulations, you know.

Senator MITCHELL. Yes. There is an inevitable tension there, Mr. Pickering. Taxpayers expect that their tax money will be used for purposes that the law intends. So, there has to be some mechanism for accounting. When that process is maligned from reasonableness to red tape is very difficult to determine, but the fact is that allotted Federal funds are used for purposes not intended by law. And you have to be able to come up with what is the appropriate balance.

It is very difficult to achieve. I have no doubt that, in Medicare, we have gone beyond that in many areas besides this; but I will tell you also that our committee heard testimony from doctors a couple of years ago who stole millions of dollars from the system and who said that the method of accounting was laughable, that it was easy to defeat and to steal this money.

And so, we constantly go back and forth between the need to provide some reasonable accountability, and yet do it in a way that imposes an expensive and unnecessary burden on the overwhelming majority of providers who are honest and who only want to provide adequate care to the beneficiaries, but it is a very difficult area.

You see it from one perspective; but believe me, we see it from the other one as well, in many areas of Government spending where, without accountability, the funds simply are not used for the purposes intended. And it is sad to say but true, even in the area of health care—in all areas of life—there are persons who are providers whose objective is to beat the system, as opposed to providing health care.

They are a tiny minority, thank God, but they do exist; and we have to deal with that.

Mr. PICKERING. I understand your point, Senator. It is my understanding that a national home health publication has stated that HCFA was out of compliance with the Federal law, the Paperwork Reduction Act; and that was before the implementation of these, of all this stuff. And all we are saying is that if it adds $1.00, $2.00, or $3.00 per unit of cost, that seems to be overzealous.

Senator MITCHELL. Yes. Senator Cohen.

Senator COHEN. Ms. Billows, you indicated that prior to the chilling effect of the new regime, Maine agencies had never been off waiver. I have a question on that. Have any of the home health agencies in the region managed to hold onto their waiver throughout the past year?

Ms. BILLOWS. No. I think currently in Massachusetts, 50 out of 70 home health agencies are off waiver. I understand most of the

Maine agencies are back on waiver; but it is a calculation that is very sensitive. And with the delays in the reopenings and reconsiderations that are sometimes beyond six months, at some point in time you do get the impact of the 40 percent reversals on reopenings and reconsiderations.

Senator COHEN. You also mentioned Blue Cross/Blue Shield of Maine. Would it make a difference what company was acting as the fiscal intermediary, in your judgment, whether Blue Cross/Blue Shield of Maine or some other fiscal intermediary, given HCFA's change in approach to reimbursement? Does it make a difference? Are there other intermediaries which you think are acting in a manner more consistent with the intent of the law?

Ms. BILLOWS. My understanding is that the problems are more severe and a regional one. The medical necessity denials are not unique to this region.

Senator COHEN. I guess what I am trying to get at is this. Are any of you suggesting that perhaps Blue Cross/Blue Shield of Maine was selected as the fiscal intermediary because of their approach to denials? Is that the reason that you feel that they were selected. Are there other intermediaries that would not experience the same situation? If HCFA says this is what they are trying to promote, are there other intermediaries who would act any differently?

Ms. BILLOWS. I don't think so. I think the clarification from the intermediaries comes from the Health Care Financing Administration.

Senator COHEN. It really comes from the top down, not to single out Blue Cross/Blue Shield of Maine or any other intermediary, if they are in fact acting consistently with the directives coming down from HCFA. Is that not the case? Does everyone agree with that?

Mr. PICKERING. Yes.

Ms. GAMACHE. Yes.

Senator COHEN. I am not trying to make a case one way or the other, but it just seems to me that the policy change has come about from the Administration, and that is where the responsibility ought to be allocated.

Ms. BILLOWS. I think, too, in our meetings with Blue Cross of Maine, that was one of the reasons we invited HCFA representatives to be there, just so we could take another step towards clarification—unfortunately, not too successfully.

Senator COHEN. What was your experience in dealing with the intermediaries or with HCFA in trying to get an explanation for the sudden change—the 25 percent rate of denial escalating up to 37 percent? What was your experience in trying to get some clarification when suddenly "homebound" became unilaterally redefined as "bedbound"?

Ms. GAMACHE. In the Home Care Alliance, we have a reimbursement group that meets with Blue Cross and Blue Shield of Maine on a regular basis. And through those meetings, we endeavored on several occasions to get clarification on all those issues. I would say it was a frustrating experience in asking for written clarification, in trying to understand why, all of a sudden in one month, my very mature and excellent staff appeared to become ignorant of the rules and regulations they have been following for years. Our agency, for instance, had not been off waiver in seven years, and all of a sudden, we were off waiver.

The staff was totally demoralized. They felt they weren't being believed professionally, which is very difficult to deal with. I think it comes down to a level of professional trust: If you give us a form that says fill out these 28 things or 37 things and if the information provided matches the regulations, you will be paid for the service; and the staff does that, and then they are questioned. You send the same information in again and then it is turned around. It is just like a game. We want to take care of sick people; we don't want to have to chase around repeating something that is already done.

Many times we have found the reversals to be very frustrating. Obviously, they shouldn't have been denied in the first place. We have several cases that have just gone to the ALJ level, and those are being reversed. That takes a lot of time and energy. It has been a frustrating and costly experience for us all.

Senator COHEN. You used the word "quota" in your opening statement. Do you have any evidence that HCFA has imposed a quota system upon the intermediaries?

Ms. GAMACHE. There has been—and in my written testimony, I do allude to that—evidence of memoranda within the Health Care Financing Administration which states that they have a five-to-one rule, which was the mandate that an intermediary recover $5.00 of dollars spent on care for every $1.00 they spent on medical review. So, if they had a $1,000 medical review budget, they would have to return $5,000 in care.

We felt that that rule was totally outside a person's right to due process. You can't parcel out health care on a quota basis or deny people on a quota basis. Blue Cross and Blue Shield of Maine in a recent hearing in Rhode Island, did admit that they had been under this mandate. They didn't admit that they had done it, but it was in writing.

Senator COHEN. Mr. Pickering, how do you recover a $77,000 loss?

Mr. PICKERING. What we have been doing is going to various towns, to the United Way, et cetera; but I think if this were to happen every year, we would be simply cutting back on our Medicare Program. And that presents a great dilemma for us, Senator, because in much of our geographic area we are the only health care or home health provider.

If we leave, there are not going to be proprietary home health agencies coming in to serve the people in Washington County, you know. This just isn't going to happen.

So, it does present some real serious problems. Now, as a result of our becoming overcautious—and I think this has happened to many home health agencies who are intimidated—we cut back on Medicare services to the elderly. And that is a moral dilemma for us. If we are not very careful, what happens is we increase our deficit; and if we increase our deficit, then services to people—all of our services—are in jeopardy. So, it is a real dilemma.

Senator COHEN. So, we do have a situation in which denial rates may be down, waiver of liability is up, but service is going unprovided.

Ms. BILLOWS. Yes, that is correct.

Senator COHEN. The denial rate itself doesn't tell us if the system is working, and in fact, it may not be working.

Mr. PICKERING. What has actually happened in a sense is that the Medicare beneficiary has diminished—has vanished, or is vanishing from our caseloads. If you serve something like 7,000 units of service less, then your caseload is dropping.

Senator COHEN. Thank you very much.

Senator MITCHELL. Thank you all very much. It has been very helpful. Our final panel of scheduled witnesses includes William Johnson, President of Blue Cross/Blue Shield of Maine, Region I Fiscal Intermediary for Medicare Home Health Care; and John Kennedy, Administrator of the Health Care Financing Administration, Region I in Boston.

Good morning, gentlemen. Thank you very much for coming. Mr. Johnson, welcome. We will begin with you.

STATEMENT OF WILLIAM R. JOHNSON, PRESIDENT, BLUE CROSS/BLUE SHIELD OF MAINE, REGION I FISCAL INTERMEDIARY FOR MEDICARE HOME HEALTH CARE, PORTLAND, MA

Mr. JOHNSON. Good morning, Senator Cohen and Senator Mitchell. I am William R. Johnson, the President of Blue Cross and Blue Shield of Maine. Thank you for the invitation to present testimony today on the Medicare homecare program and to discuss our role as fiscal intermediary.

As you are both aware, Blue Cross has served as the fiscal intermediary for Part A of the Medicare Program in Maine since its inception more than 20 years ago. On the basis of our performance, we were selected by the Health Care Financing Administration to serve as the fiscal intermediary of the Medicare home health benefit program in New England and began operation of that project in 1986.

As fiscal intermediary, we are responsible for the administration of the Medicare home care program in New England within the framework of a contract we have entered into with the Health Care Financing Administration. Our principal responsibilities can be placed into three broad areas: processing claims received from providers in a timely manner, making benefit determinations that are consistent with the Medicare regulations as set forth by the Federal Government, and auditing provider cost reports to ensure that providers are appropriately reimbursed for services provided.

Home health care is an industry that has existed for generations. Many of the agencies Blue Cross serves in Region I can boast over 100 years of providing caring services in their communities. It is the expectation and the right of every Medicare beneficiary that homecare services will be available, no matter where he or she resides, and that homecare services will be delivered in a responsive and efficient, safe, and cost-effective manner.

It is our belief that, as a designated fiscal intermediary we have a prime responsibility to the Medicare beneficiaries who receive home care, to the providers who deliver home care, and to the Government that administers the home care program.

That prime responsibility is to ensure a program that carries out the intent of the Medicare law as interpreted by the Health Care Financing Administration rules, regulations, and guidelines, under which we operate. As fiscal intermediary, our goal is to operate from the basic assurance that beneficiaries are receiving their entitled services, that we are making accurate and valid medical review determinations, and that HCFA contracts are appropriately fulfilled.

This past year has been one of transition for us, as well as for the home health agencies. To assist you in comprehending the magnitude of this transition workload, I would like to share a few statistics with you.

We have grown from serving 16 home health agencies to serving 305. Our claims volume ran approximately 25,000 claims a year prior to 1986. We expect to process 23,000 claims a month in 1988. The dollar volume of the claims a year ago was close to $6 million. For 1988, we project that volume will be around $100 million.

In order to have this transition proceed as smoothly as possible, Blue Cross has accomplished a number of tasks in the past 12 months. A staff of more than 70 people has been recruited, hired, and trained for the program. Only professional registered nurses, most of whom have extensive experience in the field of home health, a registered therapist—physical therapist—and a consulting physician make medical review determinations.

Over 250 meetings have been held with home health agencies to educate their staffs and to respond to provider questions. A Provider Relations Department has been established, consisting of professional nurses with excellent qualifications. These staff members, located throughout the region, are available to visit the agency staff on site and to conduct educational sessions, primarily directed toward improving the provider's knowledge of the billing process and documentation requirements.

A toll-free 800 telephone line has been set up to provide immediate access to our staff. Statements have been made that Maine has had the highest denial rate in the country. We believe this to be inaccurate. National denial statistics prepared by the Health Care Financing Administration show that Region I had a 4.8 percent denial rate, lowest in the country, for the quarter ending June 30, 1987. In addition, we have reviewed our regional and State data for the first three quarters of 1987. I am pleased that it shows a definite trend of steady and marked improvement in performance and claim denials to the point where, in the third quarter ending September 30, the denial rate in Maine, Seantors, is less than 1 percent; and all Maine agencies currently have favorable waiver status.

In response to your specific questions relative to types of denials, I would note that most denials are based on medical necessity. Denials for the homebound in Maine are currently extremely low. In an attempt to determine if Blue Cross and Blue Shield of Maine have been properly administering the home health benefits, I recently requested that the regional HCFA office come to Maine and evaluate our performance. That review by HCFA, which I received on October 25, indicates, and I quote:

You have planned well, hired qualified and talented staff, put in place appropriate internal management controls, and have passed HCFA standards in relationship to medical review.

We took the additional initiative of engaging the reputable accounting firm of Ernst and Whinney to perform an independent audit of the program. From the copies I have shared with you, you will note that Ernst and Whinney has told us, and I quote:

> We are ninety-five percent confident that Blue Cross and Blue Shield personnel made an appropriate initial approval or denial decision for ninety percent or more of all home health claims.

Also, their analysis for a five month period ending in August indicated that the estimated error rate for claims when measured on a visits-reviewed basis was less than three percent.

Finally, we believe that we have done everything in our power to operate this program correctly within the guidelines established under our contract with HCFA.

As fiscal intermediary, our ability to make changes to policies or procedures is very limited. However, we welcome your proposals or suggestions as to how we can improve our operation. I think the task which Blue Cross and Blue Shield of Maine has accomplished in the last 12 months demonstrates a willingness to carry out a critical responsibility in the best possible manner.

We look forward to working with all interested parties to continue this vital program. Thank you.

Senator MITCHELL. Thank you, Mr. Johnson. Mr. Kennedy, welcome. We look forward to hearing from you.

STATEMENT OF JOHN D. KENNEDY, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, REGION I, BOSTON, MA

Mr. KENNEDY. Senators Mitchell and Cohen, I am John D. Kennedy, Regional Administrator for the Health Care Financing Administration. I am very pleased to be here with you today to speak about the Medicare Program's role in financing health care services for the elderly.

I am prepared to read the testimony, Senator, or provide a copy for the record and give a summary. I may be able to meet your five-minute rule a little better if I offer the summary, Senator.

Senator MITCHELL. All right. Go ahead.

Mr. KENNEDY. What I would like to do, if that is all right, is provide the summary and then refer to the questions that you posed in your letter and give you some feedback on those questions.

Senator MITCHELL. All right.

Mr. KENNEDY. And then, I will be happy to answer your questions, obviously. The formal testimony, which I am submitting here for the record, contains five themes; and I would just like to indicate what those themes are and perhaps indicate the pages in the testimony in case anyone wants to follow along with them.

The general purpose of the home health care benefit under the Medicare and Medicaid Programs is discussed on pages 1 and 2. The growth in the benefit is discussed on pages 2 and 3. Initiatives which the Health Care Financing Administration has taken to address the issue of quality of care are described on pages 3 to 5. And an indication of the initiatives that the Health Care Financing Administration has taken to improve the administration of the benefit is discussed on pages 6 through 9. Finally, on pages 6 and 7 of the handout, we discuss the issue of denied home health claims.

I will very quickly go over the general purposes and eligibility of the benefit. It is obvious from the testimony here today and from your observations, Senators, that the scope and purposes of the benefit are well understood. The only thing I would emphasize again is the fact that the Medicare Program's traditional orientation to an acute care benefit has been continued in our efforts to administer the home health benefit as an adjunct to a recovery process from an acute illness.

Medicaid, a program administered by the Federal Government and the States, provides many of the same services, but States can opt to provide personal care services; and in many instances, Medicaid is more oriented towards a longer term benefit.

The growth in the home health care benefit, I would just summarize by indicating that it is one of the fastest growing components of the Medicare Program. In fiscal year 1986, over 38 million home visits were made to 1.5 million beneficiaries. Of these 38 million home health visits paid in 1986, 1.9 million were to New England beneficiaries; 153,000 were to individuals in Maine. Since 1981, the number of certified home health agencies has doubled to almost 6,000 today.

Since 1980, home health spending has tripled to over $2.5 billion in fiscal year 1986. In New England, Medicare home health benefit spending has gone from $60 million in 1981 to more than $289 million in fiscal year 1987. That represents an increase in six years of 382 percent.

Medicaid in Maine is providing an additional $10 million in 1986; and those $10 million are matched at the Federal level of approximately some $7 million dollars.

We expect that the growth in the home health services will continue. The expansion of the home health benefit refocuses attention on the quality of the services paid for under this benefit. Let me just indicate four of the steps that the Administration and the Health Care Financing Administration have taken in that area.

State Health Departments survey agencies to assure their compliance with health standards, and we intend in 1988 to allocate additional funding to support more frequent surveys of home health agencies, especially those agencies presenting serious deficiencies.

Our medical review activities provide an opportunity to identify both denied and paid claims, which may represent or raise questions about the adequacy of the care provided.

In addition, the Medicare Peer Review Organizations will be looking at all readmissions to hospitals within 31 days now; and that provides an additional opportunity to look at those readmissions from the standpoint of the quality of the care that was provided during the period when the beneficiary was outside of the hospital.

Other initiatives to improve the administration of the benefit are discussed in the prepared testimony. Let me just indicate that there is a broad perception that this department has a policy of encouraging the denial of home health benefits. And I would like to state for the record that that perception is unfounded.

What did happen, however, is that studies by the GAO as well as internal HCFA studies, looking at sample case claims of home health benefits a few years back, indicated that there were very substantial amounts of care being paid for that was not meeting HCFA's published standards, to the extent that almost one-third of those claims were being paid inappropriately.

In response to that, HCFA developed a more structured and standardized method of documenting home health claims and developed new forms in close coordination with the industry. This month we are issuing a new-version of those forms to the intermediaries for implementation in 1988, again with the input of the industry. The development of those forms was one step that we took to improve and standardize the documentation surrounding home health claims.

In addition, we consolidated intermediaries from the previous 47 to 10 around the country, one of which of course is Maine Blue Cross in Region I.

As a result of these initiatives, the agency and the intermediaries were in a position to more thoroughly review claims from the coverage standpoint, and their ability resulted in an increase in the claims denied over what had been the norm in the past, which brings us to the last topic, and that is, of course, the issue of home health denials.

If we look at denied claims as a percentage of all claims processed, that was the way we were calculating statistics up until the September 1987 quarter. That was a function of the fact that the intermediary workload reports dealt at that time with bills or claims that were submitted, and did not distinguish the amount of visits that were on that particular claim or bill.

Using those data, the denial rate for home health claims in the Boston region as of September 1987—that quarter—was 6.2 percent, compared to a national average of 6.8 percent.

For Maine, the denial rate for this period was less than one percent. As I indicated the agencies sometimes submit varying numbers of visits on each bill, and we have now in the Administration attempted to shift from bills denied to visits denied amongst those visits processed in a particular period. For that same period—September 1987—the percentage of visits denied in New England, as of that quarter, was 5.2 percent; and for Maine, once again, the rate was less than one percent.

That is an effort to summarize the formal testimony. I will proceed now to try to answer some of the questions that were posed in your letters, if that is agreeable with you?

Senator MITCHELL. All right.

Mr. KENNEDY. What are the relationships between the Maine Blue Cross and the Maine home health agencies and HCFA? Mr. Johnson has indicated the very substantial workload increases that his organization was asked to assume; and it was a very difficult job to take on, in a rather short period of time. I would just like to say that we think the intermediary has done a very good job in accomplishing that transition, given the very substantial growth in its responsibilities and workload.

We have watched that situation unfold, and we think that everyone concerned did as good a job as one could have expected under those circumstances. We watched that situation, as I indicated; and as Mr. Johnson indicated, we recently completed a formal evaluation of their activities, particularly in the area of medical review; and I am happy and pleased to report that they passed the formal evaluation program—the Contractor Performance Evaluation Program for 1987—in medical review.

Our own office, through our Ombudsman, Mr. Castricone, has met on a number of occasions with providers as well as with representatives of Blue Cross; and I would like to think that working through our office with the intermediary, we have been as forthcoming as we possibly can be in addressing and meeting with and trying to work with the industry, not only in Maine, but throughout the New England area.

With respect to your second question about increasing one type of denial over another, I would say that the pattern seems to be that the technical denials or the denials based on homeboundness or intermittency have declined significantly. As of the September 1987 quarter, 95 percent of the denials were in the area of medical necessity while only five percent were for so-called technical denials of homeboundness or intermittency. In Maine, the numbers are practically the same.

The issue of how much self-denial by the agencies can be shown. It is very difficult to answer that question in the sense that we don't always have in our office the data that would reflect the amount of self-denials that are occurring. We like to think, however, that through the efforts of the intermediary and through additional clarifications of policy and the meetings that we have had, that over time agencies will understand better not only the limits of the home health benefit, but also the kinds of documentation which serves to focus in on the administrative requirements and the regulatory requirements that deal with medical necessity; and that, over time, as those understandings and that documentation improve, the self-denials by the agency will be appropriate self-denials.

I think that, under the waiver of liability provisions, it has to be understood the agencies are under some constraint to make sure their decisions are appropriate and that they are appropriate in reflecting the coverage guidelines as they have been explained because, if claims are submitted that are outside those guidelines, their waiver of liability status gets in jeopardy.

What are the changes in delivery of home health services, and how have the changes in the delivery of home health services affected the elderly? Once again, that is a very difficult question to answer based on the data that are available to us. We certainly are more than willing, Senator, to look into any situation—such as the witness who appeared here earlier today—to look at the facts in those cases, or any other case.

And we have made that clear to the agencies, that we are more than willing in our office to take a second look at any denials by the intermediaries that are perceived to be arbitrary, capricious, or do not make any sense. I think we have done that in a number of instances. That doesn't, however, always turn out in a situation where we have agreed with the agency's analysis, as it were.

Are we witnessing an increase in hospital readmissions? There again, the data available to us do not permit any real definitive response to that question. The best data sets available are those relating to the PRO activities where the PROs are expected to look at readmissions within a certain specified time period. Originally, those time periods were only seven days, however. Then, they expanded to 15 days.

In the new scope of work which will go on-line next year, that readmission period is 31 days. So, as that period expands, the opportunity to get better insight into the phenomenon of readmissions and what has happened during that interim increases substantially. So, I think that in our dealings with the PROs, we make very sure that they look at the instances of readmission to the extent that home health benefits were involved or were not involved in those situations and I think that our understanding of that will increase as a result of that.

Is there a serious failure to treat persons with life threatening conditions? It is difficult again to definitively answer that question. We certainly do not believe that our administration of the home health benefit has created a situation that is life threatening. Obviously, if in any instance that happened, it was certainly not our intention to create such a situation.

The idea is that, as soon as any agency identifies a life threatening situation, or anyone identifies a life threatening situation, for Medicare beneficiaries, we would do everything to make the system respond to that and to get the beneficiary into a care setting that is appropriate to those life threatening needs, whether it be readmission to a hospital or a move from the home setting if there are vulnerabilities there that cannot be satisfactorily addressed and get them into benefit status at the SNF level, or any other type of care that would be adequate to the person's needs—the beneficiary's needs.

It is wholly our hope and intent and expectation that any such situation, when it comes to anyone's attention in the system, will be addressed promptly.

Last, your question was: Are there any concerns to you or issues? I think that the most serious concern to me here in this region, representing the Health Care Financing Administration, is a perception in anyone's mind—whether it is yours, Senator, or the home health community or the press or the public—that either Maine Blue Cross or the Federal Government is attempting or designing programs to administer the home health benefit in a way that benefits are denied to the deserving—the people who actually meet the requirements for coverage and are entitled to those benefits. I can assure you, Senators, that it is certainly not the intention of our office or of anyone whom I have ever met at Maine Blue Cross to do anything that could be remotely interpreted as an attitude or an effort to accomplish that.

And it bothers me that that perception is abroad. So, my perception is that both myself and my office in conjunction with Maine Blue Cross need to do more to intensify our efforts to communicate better with the provider community and with the public at large so that an appropriate understanding of the limits of the home health benefit and its roots in the Medicare Program's orientation toward an acute care benefit is known and understood increasingly and in an appropriate way.

Towards that end, we are developing new training packages for intermediaries relative to claims documentation. I mentioned the additional forms, the revised standardized documentations, the 485 forms that are to accompany the submitted claim. We are developing video tapes that will be available to help in the interpretation of those forms.

In the long run, however, it is the position of the Administration that private health plan options provide the best hope for increasing the range of managed care to the Medicare population, perhaps even greater than the traditional Medicare package at less cost and with hopefully greater efficiency.

That is an effort to summarize and to answer the questions you posed in your letter, Senators. I will be happy to answer any further questions you may have.

Senator MITCHELL. One of the most difficult aspects of this from our standpoint is the obvious and dramatic difference in the testimony you gentlemen have given us as to denial rates and the testimony of all of the prior witnesses. Are you in any way able to explain or account for this dramatic difference in denial rate data which you are presenting us and which contrasts so sharply with that of prior witnesses?

Mr. KENNEDY. I think Senator Cohen mentioned in his opening comments that it is sometimes difficult to use figures to get a real insight into what is going on.

Senator COHEN. You can drown in a body of water which has an average depth of three feet.

Mr. KENNEDY. Statistics have been quoted. The statistics I have given you, Senator, are statistics for quarters. Sometimes people develop statistics in other ways. Statisticians can use data in many different ways. All I can say is that the data I have provided you is based on a hard copy review of the denial statistics at Maine Blue Cross, and they cover a representative period, namely the three-month quarter ending September 1987.

Other people may choose different periods—one month, two weeks—depending upon the situation that is involved; and I am not accusing anyone of doing that, but I am saying that with the data that we have provided we have tried to do it honestly and take a fairly recent representative period.

Senator MITCHELL. Mr. Johnson.

Mr. JOHNSON. Senator, my observation is that, as has been noted, GAO did conduct an audit back prior to the time that we took over the fiscal intermediary role. It was done on a national basis, and the results of that seem to indicate the fiscal intermediaries throughout the country were a bit lax in terms of how they were administering the program as it was constructed at that point in time.

And so, the rules came down to the fiscal intermediaries almost ironically—coincidentally, with Maine Blue Cross and Blue Shield assuming its current role as Region I administrator—the rules came down and effectively said: Start administering this program the way the rules and regulations suggest, to set aside arguments about how the rules might be too rigid, etcetera.

So, one of the things that seemed to occur is, first of all, agencies moved from the period pre-GAO audit to post-GAO audit. There was, in fact, no change in the law, no change in the rules, no change in the regulations; but how those benefits would be applied against certain parameters, judgments, criteria were tightened down considerably. So, I think it only natural—given that situation—that agencies began to experience an initial change in terms of how these claims were being dealt with. There is no doubt about that.

And as I look back over time using our own experience, starting with 16 agencies and phasing in States over a period up to now where we are up to 305 or 306 agencies, I think it is fair to say that—in terms of Maine—the experience vis-a-vis denial rates is now dramatically down. Most of those agencies, or perhaps all of them, had lost their waiver status; and they all now have their waiver status back, which does suggest that—over a transitional period, the kind of documentation, the kind of information that we need, that HCFA was demanding that we have before we process a claim—there was a better educational process occurring; and the result is lower denial rates.

I think it also fair to say that the newest guy on the block coming into that process is going to experience what Maine experienced being the first agency in. So, if you could take a snapshot of a Connecticut today, they would have a higher denial rate than would a Maine because we are working more recently with them in this process.

So, I think that is part of the problem in dealing with statistics. It depends on who you are examining, at what point in time, along the continuum of events. I will also say that none of what I am now describing is intended to suggest that there is not a problem. It is denials. I would join those who say that the spirit of the entire program needs to be reexamined in terms of the intent of the original law and how it is being carried out. And I don't think that there is any doubt that some of the stories we are hearing about people being disadvantaged need to be examined carefully in the context of the hearings that you are conducting, and I congratulate you for that.

Senator MITCHELL. Your answer and Mr. Kennedy's statement appear to identify the roots of the problem. Your statement, Mr. Kennedy—and you didn't read this part of it—but I think it is really worth reading because it poses a series of questions in and of itself. On page 6 of your statement, the bottom half of that page, you identify what you see as the root of this problem.

And it reads:

> Studies performed by the General Accounting Office and by HCFA several years ago indicated that up to one-third of the home health services paid for under the Medicare Program were not covered by the program. In response, in 1985 HCFA developed more complete and uniform reporting requirements for home health agencies so that intermediaries could more accurately determine if the care provided was covered under Medicare criteria.
>
> As a result of the implementation of the home health data forms, along with increased funding for medical review and oversight of quality of review decisions, the

ability of fiscal intermediaries to detect and deny noncovered care has increased significantly.

Now, that raises several questions. The first is: How is it possible that a program was administered in a way so that one-third of claims paid were for services that were not supposed to be covered under the law?

Mr. KENNEDY. The home health benefit by itself, being the end of the continuum of acute care situations that the program addresses and covers, presents a unique set of considerations. Because it is the end of the continuum of acute care, the techniques for making sure that that benefit does not become a long-term care benefit—in other words, to assure it's acute care orientation—required the development and the implementation of guidelines relative to homeboundness, intermittency, as well as medical necessity, that are inherently very difficult to define with a cookbook or with a guideline that would be applicable to all situations.

It is very difficult in the first instance. Multiply that by our efforts to monitor 47 different components or subcomponents of intermediaries around the country who are expected to get the identical message in every instance and apply it in every case. I would only say, Senator, in response that it was a difficult mission. It was compounded by the number of intermediaries that had to make those difficult decisions.

And I guess in retrospect, it was in some sense the fault of the Health Care Financing Administration for not recognizing that in and of itself as a problem situation and giving greater attention to it in terms of guideline materials, manual issuances, or other instructions on a more predictable and definitive basis. So, to that extent, I guess we share in that responsibility.

Senator MITCHELL. It is a very difficult area, but that experience is totally contrary to the experience that those of us in the health area have had with HCFA over the past several years. I don't know you, and I am not suggesting anything personal.

But I am speaking of what we have seen time and again. The Peer Review Program was a good example. Congressional intent was to provide a specific area of care with high quality at the best possible cost, and HCFA has repeatedly ignored the former consideration and, as a national policy matter, concentrated on the latter. And we have had a lot of experience in the PRO Program, finding that the whole concept of medical review was budget-driven and was used as a mechanism to achieve savings or slow down in rates of expenditures, and that the medical criteria were subordinated to that objective. That is what is so hard to understand and accept as an explanation of the root of this problem that the reverse was occuring in HCFA, that you actually were paying a third more. The whole experience is to the contrary.

There is no doubt that the whole health benefit has expanded dramatically in this decade, that it represents one of the fastest growing areas of expenditures under Medicare and, for that reason, has been a matter of grave concern to the Administration and to everyone who wants to provide the maximum benefit at the best possible price within the fiscal constraints we are under.

I have just one more question because I know Senator Cohen has questions he wants to ask, and we do have other witnesses. Mr.

Johnson, the only question I have is that, in your statement on page 3, you said: "Only professional registered nurses or registered physical therapists and a consulting physician make medical review determinations."

It is not clear from the way that sentence is structured whether that means that consulting physicians are involved in all decisions involving medical review. Is that what that means, or does it mean that they are consulted in some cases?

Mr. JOHNSON. The latter, in some cases.

Senator MITCHELL. Some cases?

Mr. JOHNSON. It would be the ones that had been denied that were up for rereview; it would be some of the more complicated cases that involve some extraordinary situations.

Senator MITCHELL. So, there is no way of knowing from this statement the extent to which physicians are consulted in medical review determinations in terms of the total number of such decisions?

Mr. JOHNSON. No. We would have to bring the literal documentation over a stated period of time, and we can document the percentage that the consulting physician worked on it. A physician does not examine every claim that goes through the process.

Senator MITCHELL. Senator Cohen?

Senator COHEN. First, Senator Mitchell, let me say that it is somewhat intimidating to have to face a panel where one of the witnesses is named John Kennedy from Boston, and his associate here is named Johnson. [Laughter]

Mr. Kennedy, let me say that one of the problems, I think, in terms of perception is that the Administration has taken certain actions since—I would say 1981—in other health care related fields, Social Security disability payments for one. You may not be familiar with this, but we have gone through quite an ordeal since 1981, when the Administration started denying disability payments, rather arbitrarily I might add, through computer based profiles—completely without face-to-face contact with affected beneficaries. They simply picked out a computer profile, denied the claim, forced the individual to appeal it, had it rubber stamped by the appellate process, and then forced the individual to go through the Administrative Law Judge process and bear the costs of nearly a year or sometimes 18 months delay, only then to have the denial overturned. So, you are suffering the effects of a natural skepticism, I think, that has been generated as a result of that type of approach. As we have learned in so many other related areas, the process is as important if not more important than the ultimate goal. How we do things becomes terribly important.

So, we hear witnesses come before the committee and indicate that they couldn't get answers—that there were no written guidelines—that they tried to find out what the criteria were. Had the criteria changed? Mr. Johnson, you mentioned that we tightened down the criteria. The question I had in my mind was: Where were the guidelines coming from? From HCFA? From within Blue Cross/Blue Shield? Where was this guideline that said that homebound should be construed as bedridden or bedbound? Where did that come from?

Mr. KENNEDY. May I respond to that?

Senator **Cohen**. Please.

Mr. **Kennedy**. There was never, ever any instruction that we issued that said homebound meant bedbound.

Senator **Cohen**. What do you think has prompted Congress now to have to go back and redefine what "homebound" means, or what we intended it to mean?

Mr. **Kennedy**. Would you repeat that?

Senator **Cohen**. Congress has been put in a position, because of what has been taking place, through legislation sponsored by Senator Mitchell, myself, and others, to go back and try to put some definitional guidelines and to reemphasize the word "homebound." Now, apparently there has been some change in attitude on the part of someone that suggests that Medicare patient has to be much more restricted in terms of his or her ability to get around, and almost put in bed, in order to qualify under the guidelines of being homebound.

I mean, where did that come from? Surely, it is based upon denials somewhere along the line.

Mr. **Kennedy**. Currently, the technical denials are very low. What they may have been in the past, I am not too sure; but I will assume from your statement that, at one point, the homebound denials were higher than they are today. I guess it is a phenomenon not unlike the one that I mentioned in response to Senator Mitchell's question.

Homeboundness sounds like a concept that is susceptible to precise definition that will apply to every circumstance, but experience with the benefit suggests that is not always the case. The circumstances in individual cases can vary substantially. It is difficult in many instances to apply what we believe was intended by the notion of homeboundness, and that was that an individual would be considered homebound only in those circumstances where it would require considerable effort or assistance or other interventions to get out of the house, the consideration being of course that, by structuring it in that way, it would limit the entitlement group to those people who are really in a situation where they cannot access the system for their care outside of the home. It was never intended to define somebody's limitations in a medical sense, but simply to provide a line of defense, if you will, in relationship to those individuals who could get their care in another setting, who were able to go to the doctor's office or to the clinic or to other sources of care.

Senator **Mitchell**. Let me say that we have received a good bit of evidence indicating that denials were being made on a very narrow definition that effectively construed homebound to mean bedridden. The legislation that we are now in the process of trying to get enacted—and I will just read it because it is an attempt to clarify—it defines homebound as a normal inability to leave home, that leaving home would require a considerable and taxing effort, and that absences from the home are infrequent and of relatively short duration.

It is intended to prevent HCFA and the fiscal intermediaries from defining homebound in a manner to be the functional equivalent of bedridden. It really doesn't differ from that you just said.

Mr. **Kennedy**. Exactly.

Senator MITCHELL. Unfortunately, the evidence that we received indicated, as Senator Cohen suggested, that in many cases denials were being made based upon a definition that was the functional equivalent of bedridden.

Mr. KENNEDY. Neither did I mean to imply, Senators, that there were not instances perhaps where a particular intermediary in particular circumstances may have taken a too-rigid view on that requirement; and I am not saying that that never occurred. It very well may have occurred.

Senator COHEN. Mr. Johnson, if I may, I would like to ask you a couple of questions; and then we have lots of witnesses who want to offer comments. What has been the ratio of the dollar value of the denial claims to the administrative costs of the program itself?

Mr. JOHNSON. I don't have a figure with me, Senator. We can supply that to you. Are you referencing the previously mentioned five to one quota and our experience under that?

Senator COHEN. I would like to address this question first and get that answer.

Mr. JOHNSON. Yes. I don't have those numbers with me, but we will see that you get them.

Senator COHEN. All right.

[The prepared information follows:]

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Elizabeth Walker-Holt
Staff Assistant to the President

December 29, 1987

Ed Danielson
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Mr. Danielson:

I am writing in response to your request to William R. Johnson regarding prepared information to be added to Mr. Johnson's statement made on November 16, 1987.

During fiscal year 1987, the dollars denied totaled $3,794,683. However, it is extremely important to note that $2,843,534 was paid under the waiver.

Our administrative costs for the Medical Review activities totaled $1,149,365.

Looking at total denials, we recovered $3.30 for each $1.00 spent in administrative costs. Looking at strictly the dollars saved, the recovery rate would be only $.827 for each $1.00 spent.

During this same 1987 fiscal year we made total payments to Home Health agencies in the amount of $46,221,043, which means the denied dollars of $951,149 represents slightly more than 2% of total dollars paid.

I hope this information is of help to you. If I can be of further assistance, please don't hesitate to contact me.

Sincerely,

Elizabeth Walker-Holt

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Senator COHEN. Next question. Is there any ratio between the value of the denied claims and the program costs?

Mr. JOHNSON. There is no ratio that we are administering or policing or a target that we are attempting to hit.

Senator COHEN. And HCFA has never either formally or informally provided a formula—a ratio formula—for you to try and strike in terms of reducing costs of the program?

Mr. JOHNSON. There was at a point in time a list of criteria the fiscal intermediaries were faced with, one of which was—I believe it was—a five to one ratio. We have never come close to meeting that item, nor was there any deliberate pressure upon us to do so. It is my understanding now that that item has been completely eliminated from the list of fiscal intermediary criteria.

Senator COHEN. In what form did it come to you?

Mr. JOHNSON. It was in the form of a list of criteria that a fiscal intermediary would be measured against as they took on the task of serving the roles of health care.

Senator COHEN. I know, but in what form did it come to you? Was it part of the Federal Register?

Mr. JOHNSON. No. It was actually a form letter of the Health Care Financing Administration's.

Senator COHEN. See, a big part of the problem are these unwritten rules or private memoranda that have been sent to fiscal intermediaries administering the Medicare home health benefit via an unpublished undocumented procedure is totally inconsistent, I believe, with not only sound practice but the intent of the law, namely that we have established guidelines so that we know how you are carrying out your responsibilities. When the basis for administering a federal program is an informal letter or a phone call, then we have great cause for concern.

Mr. JOHNSON. What I am describing, Senator, was a formalized set of criteria that would be intended to be used to measure performance of intermediaries. As I say, it is my understanding now—and perhaps John can comment on it—that that has been dropped completely.

Mr. KENNEDY. May I comment?

Senator COHEN. Certainly.

Mr. KENNEDY. Bill is correct. In the CPEP, as we have come to refer to it—we all have our pet acronyms, as you are aware—that is the Contractor Performance Evaluation Program—did have in the past a five to one medical review return ratio. The way that was communicated was, in the standard package that we send out every year to provide the guidelines as to how that CPEP review program is going to be conducted in any particular year, the CPEP program that has been issued for this year does not include the five to one ratio.

Senator COHEN. Why not?

Mr. KENNEDY. Could I go back in time just a little bit? The five to one ratio, Senator, has been indicated as a vehicle or some effort on the part of HCFA to put pressure on the intermediaries to deny claims. I can assure you, Senator, that was never the intention of that five to one ratio. The five to one ratio was originally created as sort of a standard methodology for getting input back about the relative performance on some measurable basis to make comparisons of intermediary activities in this medical review area across the country.

In the days when—we were talking earlier about the denial of claims, you know, perhaps as much as one-third were not paid appropriately—the Administration designed this to have at least some normative way of getting an understanding of what intermediaries are in fact returning, based on their medical review activities; a methodology for comparing intermediaries in some standardized formula.

But the standardized formula was not designed to produce more denials. What it was designed to do was to give a normalized way of evaluating the performance across 47 intermediaries, back in those days. Now, when you say the five to one, if as a result of the efforts of the intermediary, the providers were understanding the benefit and sending in claims that met the definition of homebound, per example, the number of intermediary people involved in the medical review process would not be necessary. So, the number of staff that created the ratio—the number of professionals that were involved in the medical review—would go down.

In other words, if the five to one ratio were being met legitimately, then there was no real—it was not making denials as it were—it was not producing denials. It was monitoring the number of denials in some normative way.

Senator COHEN. You mean that if you had a five to one ratio that was in fact being carried out, and you still had a high number of claims being processed, there would be no pressure to cut back with the denials?

Mr. KENNEDY. There would always be the pressure to identify and deny those claim, that should be denied, but the idea of the five to one was just to provide a basis for looking across the country at all the intermediaries.

Now, if the intermediaries, through their efforts to educate and to better document the claims that were coming in, they were not meeting the denial ratios because they weren't denying any more claims, because the claims that were coming in were payable claims; Then, the number of people needed to do the medical review would go down. So, the five to one would be structured against a much reduced administrative base. It wasn't ever intended to create a five to one ratio so that all the people who were doing medical review could stay there and then deny more claims so that they could meet the five to one ratio.

But the perception became abroad that this was an effort that was designed to do that; and we just said, well, if that is the perception that we are getting from that kind of a criterion, then we will take the criterion out because it was never designed to do that.

Senator COHEN. One final point, Mr. Chairman.

Senator MITCHELL. Yes.

Senator COHEN. Mr. Johnson, you said in your prepared statement that one of the things you were going to do was focus on the outcome of the patient care as opposed to paperwork. Does that go for success and failures as well?

Mr. JOHNSON. Yes.

Senator COHEN. In other words, we had some testimony this morning from a patient who is 86 years old, who had been operated on, had an eight-inch scar; her wound had to be dressed on a daily basis, whose spouse was suffering from Alzheimer's Disease and then died. Would that be the kind of focus that you would also look at?

Mr. JOHNSON. Yes.

Senator COHEN. That is all I have. Thank you very much.

Senator MITCHELL. Thank you both very much, Mr. Kennedy and Mr. Johnson. Your testimony has been helpful. Now, ladies and gentlemen we have already gone 10 minutes over the scheduled time for the hearing, but we have a number of persons who requested the opportunity to speak briefly. We have 12 in all, and I am going to call on you now. I will ask each of you to come up to the lectern and make a statement.

I hope you will be as concise as you can, consistent with getting your point of view across. I would like to begin with Senator Paul Gouvereau, another official we have with us, of Lewiston, who has been active in this field at the State level. I will begin with him and then go to the persons who have written their names down here, in the order that they wrote their names. Is Senator Gouvereau still here?

Good morning, Senator, welcome and we look forward to hearing from you.

STATEMENT OF PAUL GOUVEREAU, SENATOR, STATE LEGISLATURE, STATE OF MAINE

Senator GOUVEREAU. Good morning, Senator Mitchell and Senator Cohen. I am pleased to have a chance to address you briefly this morning. My name is Paul Gouvereau; and I am a State Senator from the City of Lewiston, and I also serve as the Senate Chair of the Joint Senate Committee on Human Resources in the Maine Legislature. And it is in that capacity that I am addressing you this morning.

The increased denials by Medicare of payment for home health services, which is the subject of today's hearing, has drastic consequences for the citizens of this State. During the past few years, we have seen a steady shift to the State of Maine of the cost of services which previously had been borne by the Medicare Program.

In my own area—the area served by the Andrew Scoggin Home Health Services Agency—the proportion of skilled nursing services paid for by Medicaid has increased from 32 percent to 47 percent during a time in which Medicare reimbursable services have been denied by some 38 percent.

For individuals who are not eligible for Medicaid, the reduction in Medicare coverage has meant that they either must forego care, pay for it themselves out of income which is often quite limited, or apply for aid under our long-term care mechanisms which are funded entirely with State of Maine dollars, which are already being strained.

There is ample reason to believe that our experience here in the northeast has been especially severe, that denials here have outpaced those in other regions of our country; but across the nation, there has been a steady effort by the Health Care Financing Administration to use the denials process as a vehicle for the cost containment and, as a result, all State budgets are adversely impacted.

I suspect that these adverse results are being achieved by well-intentioned men and women who feel and believe that they are carrying out the will of the Congress; but I also believe that they are operating in too mechanical a fashion without an understanding of the long-term consequences of their actions and without a sensitivity for those individuals who are being adversely impacted.

Congress must provide HCFA with new marching orders and must reaffirm the values which prompted the original Medicare legislation. On October 9 of this year, the Maine Legislature unanimously adopted a resolution addressed to the Congress which supports the petition circulated in Maine and which gave rise to these hearings today; and I have forwarded copies of that resolution to your offices. I will be glad to make other copies available if you so need them.

The Federal Government has been able in recent years to save millions of dollars through implementation of its prospective reimbursement cost mechanisms. The savings which we have achieved in the hospital sector have resulted in far greater demands on the home health side. We need to recognize this trend and the consequence of hospital cost containment initiatives. An across-the-board zero growth policy simply will not work.

Instead, we need a balanced, thought-out, safe system of care. We may need to swap savings in some areas for expenditures in others. In my experience as a State legislator, I have had sensitivity for the pressures to which you today are being subjected, and I understand the difficulty of the decision you must make.

I am convinced, however, that only the Congress can sort out this very difficult issue, being assured that we do not achieve our goals of deficit reduction at the expense of the health care of our citizenry. I urge you to take prompt action. Thank you very much.

Senator MITCHELL. Thank you, Senator Gouvereau, very much for your testimony.

I will now go down the list in order. Peter Cobb.

STATEMENT OF PETER COBB, EXECUTIVE DIRECTOR, VERMONT ASSEMBLY OF HOME HEALTH AGENCIES, INC., MONTPELIER, VT

Mr. COBB. Senators, I have some written testimony which I will present to you. and I will not bother to read from that.

Senator MITCHELL. Thank you, Mr. Cobb.

Mr. COBB. I would like to thank you for giving Vermont the opportunity to be here. In my testimony, it is sort of an epistle of woe—more of the same—more denials, most costs, the same thing you have heard this morning—and I am not going to restate what you already know.

I want to go back a little bit to the Chinese proverb theme that was heard earlier this morning. There seems to be a Chinese curse that we have had this year in home care, and it goes something like this: I wish you an interesting life; and home care has had a very interesting year; and we would like it to be a lot less interesting next year.

Just a few comments from Vermont. I will give you five agencies. There was some disagreement on what the denials are or what they are not. I have some statistics in there that show, for five agencies, in January through June of this year, they had 707 denials. The same six months the year before, they were 75. I don't care whose calculator you use, that is a huge increase.

I will tell you that the denials through July and August have been down; but in Vermont, we tend to be a little skeptical, and we are waiting to see what happens. We are not worried if you say that things are going to change completely; but we are there, and we are going to fight everything.

There have been two effects in Vermont, and I suppose there have been the same two effects everywhere else. The first is patient care. You have nurses who are second guessing what they are doing. They are being second-guessed. They are wondering: Are we doing a good job? And in the agencies, we have made a conscious decision as best we can in Vermont not to cut care, to give what we have always given, to fight every denial, to use our Legal Aid for Medical Patients Program to fight everything.

But that costs money, and it has cost an awful lot of money in Vermont. I will give you an example. Whenever I read a HCFA newsletter, they seem to be whining that the home health benefit is just leap-frogging, from a huge 2.5 percent to—who knows?—it might be three percent, as if that is a problem. And I think there are two answers here.

One is cost; this has got to be part of the answer. One of our agencies last year—or the beginning of this year, I should say—had a $42.00 per cost visit. This year they are well into the fifties and they are closing in on the sixties; that is only nine or ten months. What has happened? Most of it is their cost of fighting these denials. They have had to hire a full-time person simply to review paperwork and to process whatever it takes to fight denials. Now, does that make sense? It doesn't make sense to me.

I agree with you, Senator Mitchell. We must do quality control. We must find out what is going on; but quality control and Mickey Mouse review are not the same, and I think that is what we are getting in Vermont.

Finally, I think that you ought to know that, in Vermont, we have all not-for-profit agencies. We are not in the business to suck the Federal Government dry. We are there to give care. I don't believe that the Vermont agencies are administering the program to make a fat buck.

An example of those five agencies that went from 75 denials to 707—now, it is possible that they got stupid on January 1, but I doubt it very much. What I think happened is that they were simply doing the business that makes sense, and they were getting slapped on the wrist.

I think there are some suggestions I would like to make and probably some you have already heard.

First, I think we need to eliminate all review criteria that really smokescreens for cost cutting. That is not to say that you can't do cost review; that makes sense. But when the medical reviewers are also the cost reviewers, you have got inherent conflict of interest. It makes no sense. You can't do both. You must do one or the other.

Second, you must cut paperwork. At present, the Vermont agencies are writing 30 percent or more, some as high as 40 percent of their costs, simply to run the Medicare Program. This does not make sense. It is a waste of Federal dollars.

Finally, I think we need to develop a true long-term care system. Homecare cannot continue to be a distant relative that nobody cares about. We must be part of the system, and the system goes from A to Z, includes all.

Part of the reason that I think their costs are greater and the homecare is growing—and I think we forget this—is that we have had in the past an institutional based system. We need to move away from that and to recognize that homecare makes sense and is cost-effective.

And I think the answers to most of the questions you may have for me are in the written report.

Senator MITCHELL. Thank you very much, Mr. Cobb. We appreciate that. Next is Claire Connor from Rhode Island. Welcome, Ms. Connor.

STATEMENT OF CLAIRE S. CONNOR, R.N., EXECUTIVE DIRECTOR, KENT COUNTY VISITING NURSE ASSOCIATION, WARWICK, RI

Ms. CONNOR. Thank you and good morning. It is nice to be here. I would like to thank you for the opportunity of allowing people to testify at your hearing.

I certainly have all the same problems that everyone else has brought up today. I would like to say a couple things, and one is that I definitely agree with Dr. Alexander that we are now in an era where the determination of patient care is not necessarily that of the physician or the community health nurse who administers it and who assesses it; but it is in fact a problem of a third party—the sole right of that fiscal intermediary—who reviews it without having had the benefit of being a witness to the patient's progress or the patient's lack of progress.

This has had a great effect on all agencies and certainly on my own. It has resulted in a 30 percent decline in Medicare visits by the Kent County VNA over the past months; but in conjunction with a drop in the number of visits, my agency has also seen a corresponding drop in the number of client referrals. What has happened to these patients? I don't really know. I can surmise a couple of things.

I can surmise that discharge planners, physicians, or whomever from hospitals are reluctant to refer people to us because they are afraid that services are not being covered or, worse yet, that patients are afraid of even requesting from their physicians or requesting from the hospital services that they are entitled to under the Medicare Program because they feel that they will be responsible for payment for them themselves.

The financial implications of this rationing of care are obviously very serious. Again, in my own agency, the percentage of free visits in 1987 has doubled, and our percentage of Medicaid visits has gone up 15 percent. This is presenting a great financial burden upon my agency, as it is upon all of the agencies who are represented here today.

We are fighting along with that the administrative costs of fighting these denials, which is very high. Obviously, we are patient advocates. That is one of our major roles; and because we are patient advocates, we are going to fight every one of the denials we get. But it is a very costly process. We have found that for the first nine months of 1987, we have at a minimum spent $25,000 just in fighting denials. We have had to hire new people to come in and go through the whole review process and get the documentation together; and that is just talking salaries now. I am not even including what it costs us in postage and what it costs us in copying costs.

That $25,000 would provide over 500 free visits to needy people in my community. It would help underwrite my geriatric health maintenance program. It would also provide free flu vaccine clinics throughout my county. I feel that home health agencies really need—those represented at this hearing—immediate relief from the problems we are facing with the Medicare denials because we need to spend all of our time and our energy on the things we do best, and I feel that is serving the sick and needy in our community.

We would appreciate any help that the Congress can give us, and we certainly appreciate the opportunity to present our case to you. Thank you.

Senator MITCHELL. Thank you, Ms. Connor. I think it has to be said, in view of what you and Mr. Cobb have indicated, that while it is clear that a problem has arisen in connection with the method of both medical and financial review of homecare, no one should be under the impression that the Congress will ever again permit a benefit to be created in which there is no review of the cost. Now, one of the major problems we have in Medicare—and everybody should understand this, especially the providers—is that when we started out with Medicare, it was a retrospective payment system.

Whatever the hospital charged, the Government reimbursed them with a little bit more; and that was an overwhelming economic incentive for even the best of intentioned persons to inflate costs and inflate charges. And the result has been a truly spectacular increase in the cost of the program, which presents a very serious fiscal problem for all the people of this country. Everybody here is a provider, but you are also all taxpayers. And you have to recognize that there is going to be—there is no alternative to—some form of review. You operate nonprofit; you all care about the sick and the needy.

And sometimes an attitude develops: I wouldn't provide a service it weren't needed. Well, that is what all the hospitals said; that is what all the doctors said; that is what everybody said. But the reality of life is: There is this overwhelming economic incentive that develops if you don't have some method of review. If you just say: Whatever anybody charges, we trust their good intentions to only provide services that are needed; then this program will soon be out of sight. So, we have to recognize that.

I guess I would say I am a little bit troubled by you and Mr. Cobb saying that you fight every claim. Implicit in that is the belief that no denial is ever justified; and I have to tell you that I expect you to be advocates for the people you are involved with, but no one should be mistaken here that there is ever going to be a program in homecare that doesn't have some form of cost and medical review.

It is absolutely imperative, and our whole experience with Medicare has made it necessary. I know you are not suggesting that.

Ms. **Connor**. No, I am not.

Senator **Mitchell**. But I just want to make clear that everybody understands that.

Ms. **Connor**. But I do think, Senator Mitchell, that one of the things we as home health agencies have found—and I have been involved in community health since the very beginnings of Medicare—and once Medicare came in and put on as many constraints and reports, et cetera, that we have to put together, that our costs increased in spite of ourselves.

Senator **Mitchell**. Yes.

Ms. **Connor**. I think the thing I am trying to say is: Yes, obviously, we don't think we give care that is not necessary; but if someone else is paying for it, someone else certainly has a right to review it. However, I think it could be done in a more efficient and a less burdensome manner in which patients would not suffer, the agency would not suffer, either financially or time-wise, et cetera, and the benefit could be paid.

Senator **Mitchell**. There is no doubt of that. Thank you very much, Ms. Connor.

Ms. **Connor**. Thank you.

Senator **Mitchell**. Carol Crawford of Boston.

[The prepared written statement of Ms. Connor follows:]

STATEMENT OF CAROL CRAWFORD, R.N., DIRECTOR OF PATIENT SERVICES, VISITING NURSE ASSOCIATION OF BOSTON, BOSTON, MA

Ms. **Crawford**. Senator Mitchell and Senator Cohen, I want to thank you for the opportunity to speak today. I represent the Visiting Nurse Association of Boston, the oldest and second largest visiting nurse association in the country. We have been in existence for over 100 years, provide over 500,000 patient visits per year, and utilize over 600 nurses, therapists, and home health aides to provide these services.

And even though we are an established and large organization, we are experiencing significant financial consequences as a result of the Medicare denials. I think this is nothing new, based on what we have heard today.

Our denial rates also escalated dramatically when we transferred to Maine Blue Cross. We transferred with a 2.67 percent denial rate and went up to a 13.5 percent rate and then dropped down to a 10 percent denial rate at a time that our staff knew better what the guidelines were for coverage and the guidelines for documentation. Yet, the amount of denials increased dramatically. For us, that means that this year, each month, we have been denied payment for over 1,000 patient visits, or over $50,000 per month in Medicare denials.

Again, we are a large agency, but as we are reimbursed on a cost basis, we don't really have that cushion to absorb a probable $600,000 loss this year.

I think one of the major factors which we feel has contributed to the denials has been the unavailability of clear coverage guidelines. Before we service a patient, we don't really know what will be covered and what will actually not be covered in terms of that patient's specific care. Educational sessions that have been provided by the fiscal intermediary have been infrequent and have resulted in confusion, not clarification.

Definitions that have been needed to help us determine what we should be providing have been very difficult to obtain.

We have best learned what the fiscal intermediary will probably cover as we monitored the denials. Unfortunately, those denials come back to us about six months after the care has been provided. So, we can reasonably expect that, during the next six-month period, care for those same types of problems will also continued to be denied.

As we are monitoring denials, we are trying to see if there are any trends in the denial process; but when we resubmit some of those denials, 25 to 40 percent of those are overturned, which then makes it hard for us to see if there is in fact any pattern in terms of what is covered and what is not covered.

We have often been told that the major problem is our documentations. We have frequently requested examples from the fiscal intermediary of good examples for us to use and to help educate our staff in terms of what documentation would be acceptable. The examples we received back have been similar to those of ours which have been previously denied. In fact, one specific case of ours was told to us by the fiscal intermediary to use as an example of excellent documentation. This, however, was after that same documentation had twice been denied by the fiscal intermediary and was only overturned at a special meeting that we had with the fiscal intermediary.

Obviously, we can't afford to continue to pursue our denials that extensively.

We certainly recognize the discussion that has come up here today about the need for controls, for monitoring, for ways to be sure that appropriate care is given. But we are really concerned about the dramatic increase in cost to us to monitor and to try to understand the system and understand what we should be providing.

For the Boston VNA this year, we have had to hire additional people to monitor, to track, to educate our staff; and we will spend over $130,000 this year just for those additional people to help us with the denial situation. And even at that expense, that will not give us the numbers of people that we really should have in place to be able to deal with this problem.

And a second less obvious, but equally concern of the increase in our costs, is from the additional documentation. The nurses must almost duplicate their clinical record documentation for the HCFA form, but not enough that we have been able to get consent to use that clinical documentation, in addition to the documentation for the request for clarification and then for any of the appeals process documentation.

At a time when we are facing a significant nursing shortage in this country, it is of great concern to me to hear with increasing frequency nurses saying that they are leaving homecare, not because they don't like to provide the care, but because they are tired of the excessive paperwork and they are tired of the very negative feedback they feel they are constantly getting in the form of Medicare denials.

I would urge that whatever can be done to help home health agencies receive clearly stated objective coverage guidelines be done, so that we know ahead of time generally what will be covered and what will not be covered. That will help us operate much more efficiently.

For this year, we are especially concerned that during the first six months of 1987, we did not receive any denials from Maine Blue Cross. Therefore, we did not have that experience to see how to change our patterns of care.

So, there is no way for us to really adjust, in fact, with the services we provided during those first six months, and feel that, if we are asked to repay for all the denials during the first six months, it is really an unfair and unjust request for the agency at a time that Maine Blue Cross has indicated it was a real adjustment period for them.

And we would urge that if there is any way that there could be an adjustment for the learning curve of the new fiscal intermediary, so that the home health agencies are not financially penalized for that period. Thank you.

Senator MITCHELL. Thank you, Ms. Crawford. Next, we have Tyler Brown of New Hampshire.

STATEMENT OF TYLER BROWN, HOMECARE ASSOCIATION OF NEW HAMPSHIRE

Mr. BROWN. Thank you, Senators, for the opportunity to be here today. I would like to add the voice of New Hampshire to the provider testimony that you have heard here this morning. We have experienced all of those situations that you have heard described, some not directly related to New Hampshire, but we have had similar experience in our State.

Since the beginning of this year, we have been collecting some information from a cross section of agencies in our State related to their experience with the denials; and I would just like to give you a little bit of information from that data.

The year to date, denials have cost agencies approaching $80,000, which if projected to the entire universe of home health agencies in the State, will likely exceed $300,000 for the year. For the year to date, the overturned rate—that is, the reversal rate—by the fiscal intermediary of their own decisions on the very first go-round, that is called reopening, is in excess of 55 percent. That seems to contradict testimony we heard from Blue Cross as to the accuracy of their decision because, on the very first go-round, with these agencies who have reported this information, well over half of them were overturned at that very first level.

That does, indeed beg the question as to the cost effectiveness, let alone the appropriateness, of those initial decisions.

Typically, what agencies have seen with the conversion and transition to Maine Blue Cross is the denial rate going from one percent or less; and many agencies have been with the program since its inception and have never lost their waiver of liability. Going from that level to 25 to 30 percent in some cases, and then settling back down, particularly in recent months, to somewhere between six and ten percent. In the year to date basis, these same agencies report an aggregate rate of 6.6 percent, which is still well above the 2.5 percent required to maintain favorable waiver status.

I think one of the most disturbing things for us has been that, while the denial rate in recent months has gone down, our numbers also indicate that both the volume of claims and the volume of visits being submitted have also gone down. Specifically, claims have gone down by 18 percent since June—this is June through September—and the number of visits being submitted for reimbursement has gone down by 15 percent in that same time period.

We are concerned—although it is only documented anecdotally at this point in time—that we believe is worthy of further, more efficient and objective study—we are concerned about what we perceive to be the chilling effect of this high expectation that visits will be denied. Among them we have noted an increase in self-denial by Medicare beneficiaries themselves. Having once received a denial letter, many of them fear that their Social Security benefits may be in jeopardy and refuse care, even if the agency is able to say we can pay for it out of local funds.

So, there is some of that going on. Again, we haven't got figures to document it down to the numbers.

Also, increased self-denial by providers is clearly going on. Providers are having to become much more cautious and, in spite of better documentation, many of them have the feeling that the target they are trying to hit is a moving one; and they are many times frustrated in terms of trying to determine what will be covered this week or this month.

We have noted informally an increase in self-denial or lack of referrals from various referral sources, including hospitals, who have heard through the grapevine or whatever that home health is no longer being paid and so don't even make a referral to homecare. That is not even giving the agency an opportunity to determine whether they believe the care that is being requested will be covered or not.

And most important, in the long run, we believe that there is decreased access to Medicare services by beneficiaries, and, for the first time since the Medicare Program, I believe that the Medicare benefit in New Hampshire is in jeopardy; and that is because, if some small agencies who are currently Medicare providers either drop the Medicare Program or go bankrupt because of this situation, there are not other agencies that will come in to fill the gap. And there will be situations where people will just not have access to that benefit.

In terms of action steps, I would like to encourage support of new and objective studies of what is actually happening with the Medicare benefit and what are appropriate referral levels and situations for home care. The studies we have cited I think are out of date and sometimes misquoted.

My understanding of the original GAO study and the 30 percent rate that is often quoted is that that includes a fair number of visits, and I don't know the proportion that were used to do that study, that wouldn't have been paid based on the documentation, not that the service wasn't appropriate, but that it wasn't accurately documented.

And I think the industry is very willing—the home health industry—to accept its share of responsibility for documentation requirements we expected, to be appropriately documented at the front end and audited after the fact. We do expect that and believe that that is part of quality control; but again, when documentation requirements continue to change, it is very hard to know what is required.

A lot of the requests for additional information that agencies have received, since the transition to Maine Blue Cross, involved data that was already on the initial form; and in many cases, the agency merely pointing that out led to a reversal of that initial decision.

But it begs the question: Why does an agency have to go through that process to get the reviewer to read what was even initially there? And that is not an uncommon experience in our State.

So, we would urge that there in fact be some new baseline studies that would give us an idea of what is an appropriate level of benefit for homecare and that we begin to look at that entire benefit and how it needs to be structured to meet the needs of the clients it is intended to reach.

Senator MITCHELL. Thank you very much, Mr. Brown. We still have several persons to go, and both Senator Cohen and I have to leave to catch a plane back to Washington. So, I am going to have to ask the next several witnesses to be as concise as possible. If your testimony is cumulative or repetitious, you can submit your statements.

Rita Riley.

Senator COHEN. Tell us you are not going to read that statement. [Laughter.]

STATEMENTS OF RITA RILEY AND HELENA HILL, SENIOR CITIZENS OF THE STATE OF MAINE

Ms. RILEY. Senator Cohen and Senator Mitchell, I am Rita Riley. I think you know me, and I am concerned about the Medicare home health care denials. I am a little bit nervous because I have never spoken like this in front of a group, so please bear with me. I am going to read this.

At 9:30 a.m. on Friday, August 28, 1987, Congressman Brennan kicked off the grass roots campaign in southern Maine, demanding relief from the unprecedented number of Medicare home health denials.

Ms. HILL. And on August 14, Congressman Olympia Snowe kicked off a similar campaign in Andrew Scoggin County. It is my privilege as a senior volunteer to say I worked on those petitions, and what a joy it was. And I turn over to you today 11,500 signatures, and I am happy on their behalf to present these. It was a joy to do it. And many of them who signed these petitions said they wished they could sign it eight or ten times. [Laughter.]

Senator **Mitchell**. This isn't Chicago, Ms. Hill. [Laughter.]

[Applause.]

Senator **Mitchell**. You are Ms. Hill, I take it?

Ms. **Hill**. Yes. Consumers and patients outraged by the kinds of numbers of services being denied decided to act.

And when I was approached to help with this, I was undecided; but I think it is for a good, good cause. The petitions that we are presenting in all are over 20,000. They have been collected by residents throughout Maine.

I present these to you, Senator Mitchell and Senator Cohen, requesting immediate and continued relief from the arbitrary denial of home health benefits as mandated by law.

Senator **Mitchell**. Thank you very much.

[Applause.]

Senator **Mitchell**. Kathleen Tauro.

STATEMENT OF KATHLEEN TAURO, YORK COUNTY HEALTH SERVICES, STATE OF MAINE

Ms. **Tauro**. I am from York County Health Services, and I have submitted some written information to you, which I don't want to repeat here because a lot of it has already been said. But I think at this time it is important for me to point out that the quota that has been referred to—July through September of 1987—where the denial rate may have dropped below one percent was also the quarter in which Maine Blue Cross changed the way they calculated the waiver statistics. Prior to this period, they were only basing the universe of claims, which is what they apply the denied claims to to come up with your percentage on the number of visits reviewed.

During this quarter, they changed that to the number of claims processed; and that had the effect of doubling the universe of claims. So, we had a bigger base of claims to apply the number of denied visits to, which lowered the agency's denial rate, which nobody else has pointed out here. And I think that is a real key, and that is not part of the testimony that I submitted to you; but I thought you should be aware of that.

Senator **Mitchell**. Thank you. That is very interesting. Right. Thank you. You did a very nice job. Robin Gallup of New Hampshire.

STATEMENT OF ROBIN GALLUP, LAKE SUNAPEE HOME HEALTH CARE, NEW LONDON, NEW HAMPSHIRE

Ms. **Gallup**. Senators, my name is Robin Gallup, Executive Director of Lake Sunapee Home Health Care in New London, New Hampshire. I am here to represent residents of rural New Hampshire who are in need of home health care. The isolated, sick, disabled, and elderly in rural New Hampshire need the visiting nurses. Many of these people are in their late 80s and 90s, and with the help of the visiting nurses, are able to remain living independently in their own homes.

Medicare denials are jeopardizing their health and safety and ultimately their ability to remain out of the hospital or nursing home. The following is an example.

Mr. Newton is an 80-year-old gentleman and was discharged from the hospital to homecare with gangrene in his left foot. He has no indoor plumbing and lives alone on a hill that is often impassible in winter and mud season.

The visiting nurse went every day to provide wound care and assess that his circulation was adequate to the left foot. Medicare decided that nursing visits more than twice a week were not necessary. The patient's condition deteriorated. Within one month, Mr. Newton was readmitted to the hospital where he underwent an amputation of the left leg.

I may add that this is one case that our agency did decide to appeal, and we are able to reverse the decision, as well as 95 percent of our cases that go to appeal are reversed on the first level, which is reopening.

It is on behalf of Mr. Newton and others like him that I urge Medicare to stop denying home health benefits. The frail elderly need visiting nurses. They need your support. Thank you.

Senator MITCHELL. Thank you, Ms. Gallup. Joseph Ditre. Mr. Ditre, welcome. I understand you are an advocate for Medicare patients. Is that correct?

STATEMENT OF JOSEPH DITRE, ATTORNEY/DIRECTOR, ADVOCATES FOR MEDICARE PATIENTS, STATE OF MAINE

Mr. DITRE. Yes, I am. Senators Mitchell and Cohen, I appreciate your inviting us here today, and also I thank your aides and your local aides for the cooperation and help they have given my office and others.

I do not have a prepared statement. I came here on late notice. However, I think that in listening to the entire proceedings, what I can convey to you is that there is a truth in the tenet that: For every action, there is a reaction. And what we have heard today is that there are arbitrary denials being made. These denials are based on secret rules of thumb or unpublished guidelines that the providers as well as the beneficiaries, as well as their advocates, do not have access to.

When you are enforcing a quota or ratio for denials, such as the five to one ratio, what that results in is necessarily an arbitrary process of making denials. When you hear providers come up and say that they are fighting every claim, I think that is in reaction to the arbitrary process. They don't know what they are being denied for, and they have to—just to survive—fight every claim.

I think that this also brings to my mind the basic tenets of due process in our system. When you don't know what you are appealing, when you don't know what has been denied, you have to take a shotgun approach to appealing these types of problems. Our agency is a two-person office. We are a special project of legal services for the elderly.

I am the Attorney/Director. I have a nurse/paralegal who also works with me reviewing these claims. In the past two weeks, we have seen 70 new cases. This morning, when I went to get the mail at the post office, there were another ten cases. We are receiving approximately seven cases per day. We are now handling about 410 cases. We developed those 410 cases, I would say, over the past six months.

This indicates to me that there is an increase in the denials. The denial period, since it is retroactive, can go back far. So, therefore, when Mr. Johnson or Mr. Kennedy testified that the denials for this quarter are down, it indicates that it may not be indicative of what has been done in past quarters.

It also says to me that there is a basic problem in that what we have are providers saying that they are not providing services to beneficiaries because they are not being reimbursed. I think the message has gone out from Medicare to providers, physicians, and, for example, medical equipment suppliers in Maine, that if you are providing a service to a Medicare beneficiary, that it is more likely than not that you will not be reimbursed.

And this is a particular problem in Maine, especially since we are under the DRG system for hospital care. When you are being paid on a prospective basis and you have ten days to provide care to someone and you can profit by getting that person out in five days, then there is incentive to get that person out in five days. The problem with Maine is that there are only 250 skilled nursing facility beds, as opposed to 9,350 intermediate care facility beds.

What that means is that, if someone is at a skilled level of care when they are discharged from a hospital, the hospital will in all likelihood not be able to place that person in a skilled bed, because the beds will not be available. The problem that this has presented for utilization review committees as well as hospital administrators is that they lower the level of care required for that patient. They will put them at what is called an intermediate level of care, meaning that they will get a bed, but they will not get the skilled type of care that is necessary.

I have at least ten cases in which this has occurred. When I talked with the hospital administrators and with the utilization review committee, they indicated to me that they do this because of the lack of beds.

They also are not aware that, in the Federal regulations, there are two separate provisions for providing for someone who is awaiting a skilled nursing bed, so that the hospitals can get coverage while someone is awaiting a skilled nursing bed. When you talk with hospital administrators—especially when I talk with hospital administrators—they have no idea that there is a waiting days provision in the Federal regulations; and they understand that there is an outlier day provision, but they don't know how to use the calculation because it is so complicated.

What this means is that hospitals are directly discharging most of their patients to the home, hoping that there will be homecare benefits available; and as we have heard today, those benefits are not available, particularly because Medicare has indicated that they will not be covered if they do supply services to these people.

This increases the reinstitutionalization of clients as well as the ultimate death of these clients.

Another problem is that when you go to a home health agency and you say I have Medicare only—as my only insurance—you are told that either you will have self-pay or do a Medicaid spend-down. This means that people are being put onto Medicaid and they are being pulverized when they shouldn't be, or else they are having to self-pay; and none of them can afford that.

This indicates that there are a great number of people who are being denied services. This is my problem. This is something that I think that, while we feel very strongly that home health agencies are suffering the impact, the real impact is on the beneficiaries as a result of these policies.

I would also like to indicate that in the notices that go out to the beneficiaries, they have no idea what these notices mean.

In one of the ten cases that I picked up today, I have the Notice of Medicare Claim Determination, and the first paragraph is torn whole-hog out of Medicare Guidelines. And it indicates that an individual is eligible for home health benefits under the Medicare program only if it requires skilled nursing care on an intermittent basis or physical or speech therapy. Skilled nursing care is that type of service which must be performed by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired results.

In the next paragraph—on different notices, it will indicate different things—what the actual denial is is cited. It says: "Beginning September 18"—for this one client in 1986—"the nursing services you required could have been safely and effectively rendered by a nonmedical person."

The problem that this presents is it doesn't tell the person what their condition is; what it is that they are referring to as being denied. They simply say that the service you required could have been performed by nonmedical persons. In another denial, it will say that, beginning on such and such a date, the services you receive for your condition will be covered under the home health care provision of Medicare law, assuming they are found to be reasonable and necessary. These do not help the beneficiary to know what is the condition that the agency is referring to, what is it that is exactly being denied.

And also, it doesn't tell them the dates of the denials. This says "beginning April 13, 1986." The other one says "beginning September 18, 1986," that care was denied. It doesn't tell you that, in each of these cases, two, three, four, five, or ten visits and on what dates—what the corresponding dates for the denial are.

However, they do make it loud and clear at the bottom of the notice that the receipt of this notice is considered evidence that you are aware that certain services you received were not covered. Therefore, you will not be protected from liability for such services in the future if it is determined that they involve treatment for the same condition or same level of care. The message that is going out is: If you come back for more Medicare services, you will be denied. And this is the message that has been passed on from providers to beneficiaries, and the unfortunate result of this is that people are not going back; they are doing without the care.

Just to address one last point that was made by—well, actually, there are two points that I would like to make. One of them is that, in the Code of Federal Regulations, there is a section, 42 CFR, Section 409.30, which indicates what is skilled care. However, that only indicates what is skilled care for skilled nursing facilities. I think to make those same provisions applicable to the home health benefit would greatly enhance the ability of advocates as well as beneficiaries to know what is covered and what is not, rather than having to go to guidelines of Medicare, or hitting the guidelines of Medicare.

The other thing is that the physician reviewer, in each case, Senator Mitchell and also Senator Cohen, asked Mr. Johnson if a physician reviewed these cases and at what point a medical person actually comes into the case.

The usual process in appealing a denial is that, at the first stage, there is no medical person involved in the process. Only when you ask for a reopening of that initial denial will you then get to a qualified physical therapist or a registered nurse. If a reconsideration is filed, then it will go to the physician reviewer.

In my experience, I have gone to ten Administrative Law Judges' hearings in the past three weeks; and in each of those cases, the physician reviewer's notes were particularly helpful for me in that they indicated standards which were not published whatsoever in Federal regulations or in Federal statute. When the Administrative Law Judge saw that, the physical reviewer was denying care based on someone who is chronic or someone who is terminal, or it seems that the condition has stabilized, or it seems that they have plateaued in their health care, the Administrative Law Judge immediately said: Pay the claim.

I think that is indicative of the types of problems that we are seeing with these cases. There are no consistent standards that the intermediary or the carrier, for that matter, are using. I appreciate your time.

Senator **Mitchell**. Thank you very much, Mr. Ditre. That is very helpful testimony. We have two more persons, and we are supposed to be out of this room in a minute and a half. [Laughter.]

Patricia Page of Massachusetts. Welcome, Ms. Page. You can give us a brief statement.

STATEMENT OF PATRICIA PAGE, EXECUTIVE DIRECTOR, MASSACHUSETTS ASSOCIATION OF COMMUNITY HEALTH SERVICES

Ms. **Page**. Thank you, Senator Mitchell and Senator Cohen. I am the Executive Director of the Massachusetts Association of Community Health Agencies, but I am here today on behalf of Patty Burnham of Hamilton, Massachusetts and her grandmother, a Medicare beneficiary.

This is testimony that she had given at a local forum.

> My grandmother had surgery over a year ago to remove a malignant brain tumor. The tumor could not be removed, and my grandmother's prognosis was extremely poor. The doctors predicted my grandmother would live a very short time, possibly two to three months.
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> My grandmother was a very active, 73-year-old woman. Last summer she played 18 holes of golf a day, rode her bike to visit with friends, planted flowers, and even babysat for my extremely active three-year-old daughter.
>
> After my grandmother's operation, my mother and I made a very important decision. We wanted to care for Mammy at home. We wanted her to spend her last months at home with her family. At the time, my mother had just begun a new business, which she later left and sold to care for Mammy.
>
> We brought Mammy home to my mother's house and we transformed her den into Mammy's new room. Then, we rented a hospital bed, a wheelchair, a commode,

and later a Boyer lift. At this point, we had our first consultation with the Visiting Nurse Association. They came to my mother's house and assessed Mammy's needs and her condition. We quickly learned how caring and efficient their staff was.

Dr. Abrams, Mammy's doctor, came to the house periodically to check her. He was a good friend, a good listener, and always tried to keep Mammy comfortable. Our needs in dealing with and caring for Mammy were always met. As the disease progressed, Mammy needed 24 hour care. My mother and I were responsible for her every need.

The strong, determinant, independent lady we knew now could not walk or bathe herself. She was completely bedridden and incontinent. Eventually, Mammy needed to be catherized. Physically, Mammy developed adverse reactions to medications, causing bladder infections and a diabetic condition which was hard to regulate.

Emotionally and mentally, Mammy deteriorated. She spent months crying out of frustration and confusion. Mammy needed care and comfort throughout the day and called out to my tired mother at night. As the months dragged on, caring for Mammy at home became physically and emotionally exhausting to our entire family.

During all of this, we needed the professional services of the visiting nurses. We needed a nurse for obvious medical reasons, and we needed an aide for—and someone to sit with Mammy while my mother could get some groceries.

In the first few months, the visiting nurses tried to provide an aide service three times a week for an hour or two, plus a weekly visit from an R.N. Monthly, my mother would receive statements from Medicare denying the coverage of these services.

This is a quote from one of the many statements:

"Medicare cannot pay for the above services for the following reasons: an individual is eligible for home health benefits under the Medicare Program only if it requires skilled nursing care on an intermittent basis or physical or speech therapy. Beginning February 1987, the nursing services you required were not considered to meet the above guidelines. Therefore, no further Medicare payment can be made for any nursing services furnished you." This is a form letter, with dates and names filled in. They do not even know my grandmother or her condition.

The visiting nurses tried to communicate my grandmother's enormous needs, but despite their efforts, we continued to receive these ridiculous form letters.

The hospital bed used for Mammy was rented. In February my mother received another letter from Medicare stating that they would no longer pay any portion of the rental of the bed. Instead, Medicare advised us to purchase the bed, and they would cover 80 percent of the cost. As they requested, we purchased the bed and paid approximately $400, our 20 percent. Within a month, we received a letter from Medicare stating: "Medicare has determined that this equipment is not medically required for this type of condition." They denied payment. This concerned us greatly.

My grandmother's condition was deteriorating daily. From May until the end of August when my grandmother went into the nursing home, she required daily shots of insulin. She was completely immobile in bed. We used a coil lift to move her from the bed to a chair. Two people were required to bathe her. She needed bodily irrigations and enemas. This was my grandmother's condition which Medicare was questioning.

We wanted to care for my grandmother at home. We never wanted her to spend her last months in a nursing home, and visiting nurses and Dr. Abrams wanted to help us care for Mammy at home. Medicare made the situation more difficult for us and impossible for the visiting nurses.

These have been problems for my family for the past year. When my grandmother dies, my mother and I will want to forget all about this awful situation, I am sure; but for other people—other sick people—there needs to be a change in Medicare policies.

Our family and the visiting nurses dedicated a year to my grandmother. We sat with her; we cared for her; but the disease was overwhelming. Unfortunately, Medicare saw my grandmother's condition as stable and answered our demands with form letters. This, to me, is both very sad in a very frightening situation.

The best place for someone is in the home. The Visiting Nurses Association is a wonderful group of people who can help people remain in their homes. Medicare needs to help and support this decision as well.

I know as I stand before all of you tonight that I speak for my grandmother. She obviously is unaware of any of this, but she was always a very hard-working, fair, charitable person. She always paid her own way and tried to help others. That is why I decided to come and speak tonight. My grandmother was always a very out-spoken person who tried to make a difference, and that is what we should all do, make a difference.

Thank you.

Senator MITCHELL. Thank you, Ms. Page. Finally, Helen Peake Godin of the University of Southern Maine?

You are in the fortunate position, Ms. Godin, of having the last word. [Laughter.]

STATEMENT OF HELEN PEAKE GODIN, FACULTY MEMBER, UNIVERSITY OF SOUTHERN MAINE

Ms. GODIN. Actually, I didn't come prepared to speak; so I am really ending with a question. I am a faculty member at the University of Southern Maine, but I am also on the board of a large nonprofit home care agency here in Maine.

And I have a concern regarding the survival of the nonprofit agency. In relation to this, I have a question regarding some earlier testimony that dealt with the large national increase in the number of home care agencies in this country.

My question is: Is this growth in the number of nonprofit agencies, or is this not growth in the number of for-profit agencies? And are not the for-profit agencies, or can they not be tempted to cap their Medicare admissions to their agency, therefore not risking denial of payment?

I think this is a concern for nonprofit agencies as far as survival, and I would ask you to look at that, that is, look at incentives for nonprofit agencies.

Senator MITCHELL. Thank you very much. Thank you all, ladies and gentlemen, for providing us with this information.

Before we conclude, I will ask Senator Cohen if he has any closing remarks.

Senator COHEN. In view of the time, Mr. Chairman, I will be very brief. I promise several things: number one, not to quote Chinese proverbs in the future. [Laughter.]

Sometimes it has a tendency to stimulate other Chinese proverbs, I might add. But I would just like to point out a couple of things. Home health care is part of the so-called continuum of health care. We are still going to have to have hospitalization. We are still going to have to have nursing homes. And we are still going to have to have home health care. One should not be seen as an alternative to the other.

But I might add that, no matter what we do with respect to home health care itself and the reimbursement policies, I believe that the future of our health care system is going to call upon us to do more for ourselves before we need health services. I am talking about the whole concept of wellness itself.

We are growing older as a society. We are living longer, thanks to medical care; but the fact is that we abuse ourselves, we smoke too much; we eat too much; we eat too much of the wrong kinds of food; we may even drink too much. Basically, we have got to change our habits as we proceed into a longer and longer life. I think that we are going to have to change the way in which we conduct ourselves in order to avoid the need to turn to health care of any sort, be it hospitalization or nursing homes or home health care; but that is the long-term policy we have got to address as well. In the short term, I think that Senator Mitchell and I both are dedicated to seeing to it that we make the Medicare system work as it was intended and that we not allow types of ambiguity to exist in either the program itself or its administration. The Medicare program must operate on the basis of clear-cut guidelines so that we know exactly what care will be covered and so that beneficiaries will know what they are entitled to.

Senator **MITCHELL**. Thank you very much, Senator Cohen, for the attention you have devoted to this subject and the concern expressed here today. And I look forward to working with you in the future as we have in the past.

Two very serious questions were presented here today. One is whether or not the law is being followed, the law as it now exists with respect to reimbursement under Medicare for home health care services. And if not, what can be done about that?

The second question is whether or not the law itself is adequate to deal with the problem, whether or not the whole concept of home health care must be reviewed and revised.

The legislation that I have introduced and that is working its way through the Senate attempts to deal with both. It attempts to establish and specify the criteria needed for rational and consistent decision making within the constraints of the law; and second, it seeks to expand and improve upon the legal standards governing home health care. Home health care services have grown dramatically in this decade. It is inevitable that they will grow even more so in the future because they represent an important aspect of the range of services to deal with the aging of our population, to which Senator Cohen alluded.

We are going to do the best we can to make certain that that range of services is such that it meets our national objectives in terms of health care, that every American will be able to achieve his or her right to good quality health care, readily accessible at an affordable cost.

Thank you all very much for coming, and we look forward to working with all of you in the future.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

TESTIMONY
PRESENTED BY:
CHRISTINE GIANOPOULOS, DIRECTOR
BUREAU OF MAINE'S ELDERLY
MAINE DEPARTMENT OF HUMAN SERVICES
to

William S. Cohen
United States Senator

George J. Mitchell
United States Senator

Hearing on Home Health Care Denial Under Medicare
Portland, Maine
November 16, 1987

Good morning, I am Chris Gianopoulos, Director of the Bureau of Maine's Elderly, Department of Human Services. I appreciate this opportunity to comment on the impact of the remarkably large incidence of Medicare denials for home health care in Maine. My testimony is intended to put this issue into a broader context. To do so, I would like to address three areas:

1. The effect of the home health care denial situation on Maine's elderly Medicare beneficiaries;
2. The need for action to address the lack of a coherent national long term care system; and
3. The legislation currently under consideration by the Congress.

1. First, the effect on Maine's elderly Medicare beneficiaries:

Medicare home health coverage has the potential of providing comprehensive medical care for the individual in need of skilled nursing care, medical social services, physical, occupational, or speech therapy or home health aide services. But, the rigid interpretations of the regulations and adherence to nonbinding guidelines by the fiscal intermediaries and HCFA have severely limited access to Medicare funded home health services. Providers are understandably unwilling to offer services for which they won't be paid and so elderly persons who might have been served previously are "screened out". The Home Care Alliance of Maine estimates a 25% decrease in admissions of elderly clients over the last year. Elderly individuals who are not impaired enough or poor enough to qualify for State or Medicaid funded in-home services programs, yet who need care, have limited options. They may go without services, pay out of pocket or exhaust their resources to a point where they are eligible for Medicaid. Since only a minority of elderly persons in Maine qualify for Medicaid, my concern is that many individuals are going without care. Individuals who go without needed care run a greater risk of re-hospitalization, which certainly cancels out any cost containment goals underlying HCFA's restrictive home health reimbursement policy.

Despite many recent efforts that have expanded accessibility to in-home services for Maine's elderly population, Maine's aging network has limited resources: In fact, admissions to both Maine's Home Based Care and Elderly Medicaid Waiver Programs have been frozen for months. This limited capacity to respond may be reduced even further if Gramm-Rudman cuts affect Older Americans Act funds. As the percentage of the population over age 65 grows, demand for home health services has grown exponentially. In Maine, our Older American Act and State resources have been tapped to their limit. Already, other Title III mandates have been neglected because of the shift in funding to support in-home services. The State of Maine cannot be expected to solve the problems caused by a federal entitlement program which is supposedly available to virtually all elderly Americans.

A Villers/AARP study shows a perception on part of a broad spectrum of population that the ability of the system to respond to the need for home health care is truly impaired, that we are faced with a crisis.

The Department, in collaboration with the Maine Committee on Aging and Legal Services for the Elderly, has developed an Advocacy for Medicare Patients program. This program has been successful in reversing 65% of the 350 Medicare denials it has appealed. Looked at another way however, one might ask why we must allocate scarce public resources to generate Medicare reimbursement for services to which individuals were, in most cases, entitled in the first place.

2. Second, the need for additional legislative action.

We in the DHS view this crisis situation as symptomatic of true deficiencies in this country's system of care for citizens who need assistance for chronic disabling conditions. Your focus today is on the effects of Medicare's restrictive reimbursement policies for home health services. As director of the State Unit on Aging, my concerns about the Medicare program go beyond home health services. As a health care financing mechanism, Medicare covers 84% of hospital costs for the elderly. By contrast, it covers only 2% of chronic care costs and then only for short-term, post-acute episodes. Many elderly persons have had no choice but to impoverish themselves in order to qualify for Medicaid-funded long term care services. Medicare is the engine that drives the health care system for elderly individuals. While State's have moved to re-design State-funded programs to respond to the need for supportive services by older Americans, Medicare has remained firmly attached to an acute care, institutional model. It has been said that as a delivery model, Medicare is designed to best serve healthy 40 year olds. The Medicare model may have made sense in 1965 when the number of individuals needing long term care was smaller, but it is totally inappropriate today. We see that same institutional bias in the Medicaid Program--and States adopted that model in order to gain favorable federal financial participation. The popularity of Waiver programs is evidence of the desire by States to move away from an expensive, institutional model and toward a system that is often less costly and which encourages families to participate actively in the care of elderly relatives.

The overwhelming majority of elderly persons want to remain in their own homes and are willing to accept a less intense level of care to do so. Experience in Maine also shows that elderly people are willing to share in the cost of services.

Given a national commitment to meet the needs of older citizens, there is no reason not to have a long term care system that:

1. is a combination of private, State and Federal financing;
2. gives older people choices;
3. is State administered, locally managed;
4. family-oriented; and
5. cost-effective.

3. Third, the legislation currently under consideration.

The Medicare Catastrophic Protection Act currently before the Congress is a small step in the right direction and we appreciate your support of this important legislation. The inclusion of a prescription drug benefit will be of great assistance to older people whose medications are not covered by Elderly Low Cost Drug Programs and who are not eligible for Medicaid. Directing HCFA to apply a more reasonable standard to the definition of homebound and intermittent care also should reduce the number of denials.

However, an attempt to fine tune a system that is fundamentally inappropriate to the needs of a significant segment of the elderly population is only a short term solution. Addressing the Medicare denials issue is long overdue, but as a society it is time we looked at how families and government can collaborate to design a more appropriate long term care system. Thank you.

TRANSCRIPT OF NOELLA TURCOTTE'S TESTIMONY

NOVEMBER 13, 1987

PRESENT: Charlotte Hayes, Don Kniseley, both of Androscoggin Home Health Services.

I have never heard of home health care before I went into the hospital. And when I left the hospital, the doctor asked me if I wanted to go to a nursing home or go home. He said I would not be able to do anything. I said if I could go home, I would much rather go home. The doctor agreed, and you will have all the people to help you. The next morning a nurse came and then the housekeeper came; and then a few days later, a therapist came, and I have never had so much care. I would have cried to go to a nursing home. That is the last place I want to go. I don't like not knowing where you are. But if you know where you are and if it's a nursing home, it must be hard.

DON: Then somewhere along the line you got a letter from Medicare:

They said they denied my claims because it was incurable, it was chronic. They didn't want to pay for it. I was so mad! If I had been better, I would have thrown them. Honest. We have been paying for Medicare for years and years and years, and when we use it, they stop paying for it.

DON: Did you tell your doctor about this?

No, I didn't.

DON: Did he know about it at some point after he found out that you had received a denial?

No, I didn't talk about it.

DON: Did you tell him that you might not be able to have the home health people come in at this point?

Well, he told me as long as I need it there, it will be coming. I said I don't know how long I am going to need it. But if I didn't have them, I couldn't stay here. That is what is keeping me at home.

DON: That was the key point for you. You heard from Medicare that they were not going to cover the expenses, and to you, that meant that you might lose those benefits.

I was afraid I was going into a nursing home, but I said the nurses can't work for nothing. They have to earn their money, and if the government don't pay, then they will stop coming. And when they stopped the nurses, that is when my foot got worse.

Then, I didn't want to go back to the hospital, but I had pain 24 hours a day, no circulation at all. And people asked if I had been to the doctors. I said no no, he is just going to send me to the hospital and I don't want to go. So she called the office and she told them about it, and she told her to call the ambulance. So she called the ambulance and next thing I knew they were here to take me to the hospital and they had to operate that day because it was much worse, and it was so painful that I couldn't take it.

DON: How long had you been without the nurses and the home care people to that point.

Not long, because I went back to the hospital. Just a couple of weeks after, I had to go back to the hospital. And then when I came out of the hospital, they fixed it so a nurse would be here and a housekeeper would be here. I have had them ever since then.

DON: You only received that one letter from Medicare that they weren't going to cover your claims?

Yes, and that I would be responsible after that date.

DON: What happened then after you got that letter?

I was so desperate, I didn't know what to do. I was crying and crying, my goodness, what am I going to do. I knew my husband couldn't take care of me because he has a hard time walking. So I was sure they were going to send the two of us in a nursing home. But they came back right away and then I guess Medicare started paying because it was another thing.

DON: So over a period of time after you got this letter you really didn't get as much care as you felt you needed?

Yes, right.

DON: Then you went back into the hospital and then you got the help you needed again?

Yes.

DON: Did you have any correspondence with Medicare, or did you talk with anyone from Social Security or anybody like that?

No. I didn't know how or know what to do. All I thought about was if I would have drawn suit, I would have sued the government. I was so mad because I really needed it and they stopped it. They were through with me. They were going to send me to a nursing home but the foot was getting worse and worse so they sent me to the hospital. But the second time, ever since then they have been coming. Then I have to go again for a third operation and they came to see if I was home. But the first time they denied, and this time I haven't heard anything from Medicare, nothing. The first time they wrote me and told me that my claims were denied because it was chronic, a long lasting illness. So, I didn't know, I was mad, and I was crying.

DON: What did the nurses and the caregivers, the aides say? Did you talk to them about this?

No. I talked with Barbara because Barbara stopped coming, the therapist and she said I won't be able to come any more because Medicare don't want to pay. I didn't say anything, they just stopped coming. Because it is something new, I didn't know what to do. I didn't know Medicare could stop paying any time they wanted. I thought it was like an insurance; you are insured. They pay when you need it. But they stopped.

DON: And the key for you was if you didn't continue to have those services, you knew you were going to end up in a nursing home.

That was what I was afraid of.

DON: The letter you got, was it easy to understand?

I could understand everything, but I could not understand my claim was denied. And they wouldn't pay any more and I would be responsible for the payments from that day on.

DON: Was that an option for you?

I couldn't afford it. So I knew the only thing they were going to tell me was to go to a nursing home.

/nab
11/87

TESTIMONY OF LOUISE GAMACHE

PRESIDENT, HOME CARE ALLIANCE OF MAINE

BEFORE HEARING OF SENATOR GEORGE J. MITCHELL

NOVEMBER 16, 1987

PORTLAND, MAINE

On behalf of the Home Care Alliance of Maine, I want to extend sincere thanks to you, Senator Mitchell and Senator Cohen, for holding this jointly sponsored hearing on Medicare coverage of home health services.

For the last 14 months, home care providers and the elderly persons they serve have been under unprecedented assault by the U.S. Health Care Financing Administration and its agent, the Fiscal Intermediary for Maine, Blue Cross and Blue Shield of Maine, which have dramatically increased the number of denials of Medicare claims for home health visits.

Beginning in September of 1986, home health agencies in Maine, who thought they were familiar with Medicare reimbursement rules, saw their denial rates increase suddenly by as much as 30%. We were told in response that the rules had not been changed but that they were simply being enforced properly.

There have been several results from this action:

- The overall Medicare caseload in Maine has dropped an estimated 25% in the last year.
- Home health providers have suffered financial distress, problems with staff retention and a serious drop in the morale of staff who no longer have confidence in their judgment.

- Hospital discharge planners are uncertain in making referrals to home health agencies because of the confusion in Medicare reimbursement coverage.
- And last, and most important, elderly patients have seen their access to home health care reduced and their benefits curtailed.

This phenomenon of dramatically increased denial rates has of course not been limited to Maine. It has occurred on a nationwide basis and brought crisis conditions to many home health providers.

As we have attempted to deal with the problem in Maine, we have been repeatedly frustrated in our attempts to learn the revised rules and interpretations of Medicare reimbursement which we believe are and remain unwritten. Let me give you one illustration of that frustration.

Earlier this year, a number of home health agencies in Maine experienced a series of denials for physical therapy visits. When we discovered the trend and inquired with Blue Cross and Blue Shield as to the reason for it, we were informed that, in order to obtain coverage, we had to document several things, such as the range of motion of limbs, the degrees of muscle strength, the nature of care ordered and the patient's potential for improvement. We were told that the new requirements for documentation were going to put in writing shortly thereafter and distributed to all providers. The fact that the requirements had been implemented without our knowledge and in a retroactive fashion did not escape us, and was symptomatic of a set of rules which are in a constant state of flux and beyond our reach.

This is one of many examples, Senator, which have caused us to develop three goals in battling the high denial rates:

First, we insist upon proper disclosure of all rules, regulations, guidelines and instructions affecting Medicare reimbursement for home care.

Second, we insist upon prospective, rather than retrospective, application of all reimbursement rules and changes in them.

And finally, we seek to avoid reductions in the current rights of Medicare beneficiaries and their health benefits.

While one might expect that the laws of the United States already protect us on these objectives, we have not found that to be the case.

In dealing with the issue over the past several months, the Home Care Alliance has come to one clear realization: we will only get relief through the courts and through Congress.

For that reason, we turned to the Maine Congressional Delegation for help, and you have responded both promptly and affirmatively to our concerns. We very much appreciate your sponsorship of legislation, Senator Mitchell, as a means of curtailing what we feel are unfair and inappropriate reductions in Medicare benefits.

We have analyzed both your bill, S. 1076, and other pending Congressional measures for their potential effectiveness in dealing with the flood of Medicare denials.

We understand and appreciate the fact that the catastrophic health insurance and reconciliation bills must each go through a House-Senate Conference Committee before final passage and that several provisions in your bill have been incorporated in these two measures.

Our opinion is that the following legislative provisions, taken together, will ameliorate the problem of artificially high denial rates. While the House and Senate versions of the major bills often have comparable provisions, I will express a preference for the version which best accomplishes one or more of the goals previously expressed.

First, the Senate version of the catastrophic bill provides a much needed clarification to the current Medicare requirement for home health coverage that a patient requires skilled nursing care on an intermittent basis. The new definition of intermittent care would provide that daily skilled nursing visits can be up to seven days a week with one or more visits per day, for a period of up to 21 days with a doctor's certification. Further, beneficiaries could receive up to 45 days of daily care within 30 days of discharge from either a hospital or skilled nursing facility.

While we would prefer to see the discharge requirements dropped and the number of allowable days of care increased, we recognize that budget constraints may be a factor.

Second, Medicare law presently requires that an individual be confined to his or her home to be eligible for home health services. The Department of Health and Human Services has interpreted this requirement restrictively to mean "bedbound" and denied services to individuals who are confined to their home due to serious illness or injury but are not "bedbound." The Senate version of the catastrophic bill specifies that an individual need not be bedridden but instead be confined to the home because of a condition which restricts departure except with the aid of a supporting device such as a cane or walker or if departure from the home is medically contraindicated.

Third, we favor a combination of House and Senate provisions that would streamline the appeals procedure for home health benefits. (A) Fiscal intermediaries should be required to provide a full explanation of all denials for home health services. (B) All parties should be given prompt notification of the decision on reconsideration requests. (C) The Secretary of Health and Human Services should be required to take into account the ability of fiscal intermediaries and carriers to process 75% of reconsideration determinations within 60 days, and the reversal rate for such determinations. And (D) the Department of Health and Human Services should have to pay 2% interest if a fiscal intermediary fails to notify the provider of its decision on reconsideration after 60 days.

Fourth, all home health regulations, manual instructions, coverage clarifications and interpretations, and screens for medical review should be published in the Federal Register. Such a provision is essential if home health agencies and beneficiaries are to have notice of the rules which govern the program. Time and again, we have been frustrated in understanding the changes in coverage and new requirements for documentation. It is our view that the Department of Health and Human Services circumvents the Administrative Procedure Act. We hope this change, if enacted, will correct that circumvention and better alert us to the reimbursement rules. We do somehow remain skeptical, however, that Health and Human Services will comply with it.

We also express caution on one point, Senator. The administrative process through which rules and other material are published in the Federal Register, which consists of review by Health and Human Services as well as the Office of Management and Budget, is often slow and tortuous. We are concerned that the requirement for publication of all Medicare matters in the Federal Register could slow down the implementation of either new rules or changes in existing rules which may require faster action than the publishing process can afford.

Fifth, we are opposed to the control of Administrative Law Judges by the Health Care Financing Administration for the purpose of Medicare appeals, and are similarly opposed to the use of telephone hearings. We believe either of these proposals, currently under study by the Administration, would be detrimental to the due process rights of Medicare beneficiaries. We urge approval of the provision in the Senate reconciliation bill which bars further action on these proposals until at least 6 months following a report to Congress, and that such action in all events be prohibited.

Sixth, we oppose the provision in the House catastrophic legislation which would transfer home health care benefits from Part A to Part B of the Medicare program. We believe such a provision, if enacted, would be harmful to beneficiaries for several reasons, namely, that Part B is not an entitlement program as is Part A, that co-payments are required of beneficiaries under Part B, and that the appeals process under Part B is lengthier than under Part A.

Seventh, we understand that the Senate Finance Committee, in its markup of the reconciliation bill, adopted an amendment that would require fiscal intermediaries to have a geriatrician review claims denied for lack of medical necessity during the reconsideration process. We think this is an important step in the right direction because the term "medical necessity" is undefined in Medicare law and is used very frequently, we feel, to deny claims arbitrarily. This is a great frustration to beneficiaries, physicians, and home health providers. We believe in fact that further legislative work should be done to refine the concept of medical necessity so that it cannot be used in an arbitrary and capricious manner to deny claims.

Eighth, we applaud the provision in the Senate reconciliation bill that would prohibit the Secretary of Health and Human Services from using quotas establishing a ratio of dollars to be saved through claim denials for every dollar spent on performing the medical review function. You are undoubtedly aware of internal memoranda of the Department of Health and Human Services which suggest that quotas have been used in the audit process to deny care and such use has in fact been admitted by Blue Cross and Blue Shield of Maine.

This practice should be condemned because it has no bearing upon the medical needs of beneficiaries and is in our view a wholly inappropriate way in which to manage the Medicare system and save federal funds.

And finally, we urge great caution on the study and eventual implementation of a prospective reimbursement system for home health services. The Health Care Financing Administration has reportedly developed a plan that provides for reimbursement on a per visit basis. We strongly believe this basis for payment is unwise and ill-founded. First, fiscal intermediaries would still control denials and conduct medical review. Second, documentation requirements would not be diminished. Third, some home health providers would receive less reimbursement while others would receive more, thereby resulting in inequitable apportionment of benefits.

We would very much prefer a prospective payment system structured on a per case basis. We believe that would result in overall cost savings for the Medicare program and allow agencies to provide whatever level of care would be appropriate pursuant to the diagnosis of each individual.

The bottom line for us, Senator, is that Congress should allow completion of the Georgetown University study currently being funded by the Health Care Financing Administration as well as completion of meaningful demonstrations prior to implementation of any prospective payment plan. Moreover, such a plan must be based on the most recent data available for home health services. Any hastily conceived plan would, in our opinion, be very detrimental to the quality of care and hinder the delivery of services.

Since implementation of the prospective payment system for hospitals, elderly beneficiaries have suffered in many ways: they have not been admitted to hospitals as readily as before; they have been discharged from hospitals sicker and more quickly than in the past; they have found hospital discharge planners uncertain about referrals to home health providers because of the confusion in reimbursement rules; and they have met with decreasing accessibility to home health services.

The elderly are the ultimate victims of this crisis in Medicare denials. We are not simply talking about dollars and cents but about people's lives. In the wake of reduced accessibility to acute care, home health care is truly the last resort for Medicare beneficiaries. Our goal should be to provide adequately for their health care and not shortchange them because of their increased medical needs or because of federal budgetary constraints. The Medicare program has received substantial cuts in the last several years and we do not feel that the elderly should be forced to bear a disproportionate share of the cost-cutting, whether that cost-cutting is directed by Congress or is accomplished indirectly through administrative means.

The Home Care Alliance of Maine believes that the legislative provisions which I discussed today should go a long way in alleviating the crisis in Medicare denials for home health benefits. However, we think that the reimbursement system will bear further watching if these several changes are enacted and that the issue of medical necessity requires further review and alteration. As participants in the Medicare program, home health providers are acutely aware that there are many ways in which programmatic intent can be frustrated through administrative means. We therefore hope you and your colleagues in Congress will be diligent in reviewing the effects of Congressionally-enacted changes and in monitoring the performance of the executive branch in the coming months. We also hope you will make use of the investigatory power of the General Accounting Office for an accurate determination of that performance.

In closing, the Home Care Alliance wants to commend you, Senator Mitchell, for holding this hearing on Medicare denials and for sponsoring legislation to address the problem. We also salute your authorship of a recent amendment to provide coverage for home intravenous drug therapy. We think that, if by approved by both Houses of Congress, this proposal will go a long way in helping Medicare beneficiaries receive care in a less restrictive, less expensive and more familiar setting.

We also want to thank Senator Cohen for his co-sponsorship of the Mitchell legislation and for his efforts along with those of Congressman Brennan and Congresswoman Snowe in uniting the Maine Congressional Delegation against the harmful increase in denials of home health services.

TESTIMONY FOR MEDICARE DENIAL HEARING ON 11/16/87

My name is Joseph H. Pickering, Jr. I am Chairman o. he Medicare Task Force of the Home Care Alliance of Maine and Executive Director of Community Health and Counseling Services. I am testifying on the impact that the Medicare Denial crisis and other ill-considered HCFA initiatives have had on beneficiaries and our agency in Eastern Maine. The service area of Community Health and Counseling Services (which we call CHCS for short) is huge - slightly smaller than the combined land area of Massachusetts and Connecticut. Our Bangor headquarters are located in a Standard Metropolitan Area. CHCS is therefore classified as urban, although 70% of our patients live in rural areas which range from medium-sized towns to very isolated rural areas. Although the size of the service area and the diversity of its geographic and demographic characteristics are unusual, I believe that this diversity will allow you to universalize our experience.

Much has been said about the current crisis in home health on the national level by beneficiary and provider representatives. While such national input is informative and necessary for the formation of national health policy, these statistical averages disguise the true human impact on beneficiaries, their care-givers, and those agencies who are licensed to provide home care. The lack of services to a person in Eastern Maine who used to be eligible for care cannot be statistically averaged with a person in another region who may be receiving all the care they need. A national denial rate of six or seven percent, while shocking to those who understand the industry, does not begin to tell the story of sheer human misery caused by denial rates of one in four or one in three in some areas of the country.

Some micro-statistics will illustrate the impact on real people in Maine. They should shock even those policy-makers in HCFA who have been the cause of this crisis. In 1986, CHCS made 35,700 visits, of which 20,700 were to Medicare patients. This was the year before the denial crisis hit Maine. In 1987, CHCS delivered 30,500 visits, of which only 13,700 were to Medicare patients. This means that Medicare visits declined by 7,000 in a single year. 34% fewer services were delivered to Medicare beneficiaries in 1987 than were delivered in 1986! This situation would be serious enough if nothing else were going on, but there are other pressures on home care to increase rather than decrease services. Average length of stay in hospitals has shortened - the sicker and quicker discharge phenomenon - and the general population continues to age. When these factors are coupled with the insufficiency of nursing home beds, what happened to the Medicare population who received 7,000 fewer visits in 1987? Did their conditions deteriorate to the point where expensive re-hospitalization was needed? Did they hang on long enough, in a lower-than-necessary functional state, until they were able to get permanent nursing home beds? Or did they simply and disgracefully just die sooner because they could not access the care they needed and were entitled to on a timely basis?

We have no way of knowing what actually happened to these Medicare beneficiaries, these victims of HCFA's short-sighted and Congressionally unauthorized policies, such as HFCA's re-definition of homebound, medically necessary, etc. We can clearly draw some inferences of the impact from the demographics of our patient population. By definition, the vast proportion of our Medicare patients are elderly. In fact, 77 percent are over seventy and 37 percent are over eighty years of age.

What is the living situation of this population? Of a total of 894 Medicare patients, 28 percent live alone, while 37 percent live with their spouses. Of those remaining, a portion are classified as living in elderly housing, which means alone or with a spouse. Our average Medicare patient has very little income. 26 percent earn less than $5,000; 74 percent have incomes less than $10,000. These figures are average household incomes, not personal incomes of the individual Medicare recipients.

Given the statistics you have just heard, and given the decrease of hospital admissions and the shortening of length of stay, HCFA is requiring the frail elderly to provide a level of care for their spouses which was provided in an acute care hospital only a few years ago. In effect, we are asking an 82 year old to provide a level of care to their 85 year old spouse, that, prior to 1986, was provided by a hospital and, prior to 1987, was provided by our home health agency!

I don't know whether so-called primitive peoples ever really abandoned their elderly to certain death, but what are we doing as a nation when we ask the frail elderly to provide extensive care to the frail elderly? How often has the health of one spouse been destroyed while trying to provide care for the other?

You would be entirely justified in asking what CHCS is doing to provide home health care to those who really need it. Last year, even with our decreased service units, my agency's home health program lost over 77 thousand dollars! CHCS is a private not-for-profit agency. I do my best to make sure that we run on an efficient, business-like basis. We risk bankruptcy with deficits like this, and can surely not continue to lose money on this scale. The situation of other home health agencies in Maine and around the country is, unfortunately, all too similar. We are putting our survival as agencies on the line to deliver as much as we can to those who need it.

What can Congress do to alleviate the current situation? Congress can ensure that the services it originally intended to be available to the frail elderly are, in fact, available and have not been diluted by the unelected policy-makers within HCFA. I thank you both for initiating and supporting legislation which addresses these problems. You have done a great service to the frail elderly of our country. But isn't it a sad day in the life of America when we need to pass new legislation in order to force a government agency to pay for services that were clearly voted by Congress twenty years ago?

My written testimony provides information from CHCS and other agencies in Maine detailing the effects of HCFA policies. Given the limited time, I thought that the beneficiaries deserve prime billing in the oral testimony. However, this medigate situation has taken a toll on home health providers which can be embodied in this poem:

We're a storm-tossed little life boat
  on a Blue Cross - HCFA sea
Rescuing some frail elderly
  from giant waves of bureaucracy.
We save as many as we can
But our boat's small and far from land
How many disappear in darkened waters
Never, never to be seen again?
When will this typhoon of madness end?

Thank you for the opportunity to present the case for the elderly of Maine.

WRITTEN TESTIMONY FROM JOE PICKERING, JR. FOR MEDICARE DENIAL HEARING
COMMUNITY HEALTH AND COUNSELING SERVICES

With the exception of one, very brief reference, I have not yet discussed the impact of the current crisis on providers of home care services. I have concentrated on the beneficiaries of Medicare legislation because they are the people for whom the laws were written. If the elderly could receive the care they need within their own family groups without recourse to professional care givers, there would be no need for legislation. The reality is that a significant percentage of our Gross National Production goes into healthcare - payments to physicians, hospitals, insurance companies, pharmacies, nursing homes, and home care agencies. As late as 1986, only three cents of every Medicare dollar spent went to provide services to the elderly in their homes - only a fraction of one percent of the total helth care dollars spent in this nation. And this is a nation of people who sincerely believe in self-sufficiency and know that the population is rapidly aging. We are a nation who encourage our young people to seek their destiny wherever they can find it: Horace Greely said "Go West..."; we say "Go wherever...". We hear constant reports of the decline of the cellular family unit. Surely the extended family is now long an anachronism. If, for the sake of argument, we forget about the apparent unwillingness of many families to support their elderly, what shall we say of a society whose geographic and cultural dispersion has made it impossible for the elderly to be given care within their natural family unit? If I have lived my life in Maine, and my son has established himself in California, and my daughter has established herself in Florida, and I am not independently wealthy, what do I do if I am old and, unfortunately, sick? Should I have to uproot myself and move to Florida or California? Should my children uproot their families and return to Maine so that I can receive the necessary care without the government having to spend the tax dollars on me that I have paid during my employed lifetime?

Although these are real questions whose practical answers oftentimes destroy family relationships, our society refuses to provide an answer. The cost of food, shelter, and education for the young tend to limit the size of families. The cultural push towards self-fulfillment tends to push the young away from their homes in pursuit of an ideal life that is probably only a phantasm. The cultural bias towards self-reliance encourages us to ask for nothing until we are so destitute that we have to ask for everything or die. Nowhere in the national formula of self-direction, self-reliance, and total independence is there room for dignity for the frail elderly (unless they happen to be so fortunate that they are wealthy in monetary terms or wealthy in the love and care of their families and friends). Thankfully, there is some evidence that the family is gaining ground as a viable living unit in the United States. The divorce rate has at least levelled off if it has not truly decreased. Perhaps the pendulum has begun to swing in the other direction. But what shall we do with the millions upon millions of people who are or will grow old and infirm while the pendulum is swinging? The instruments of care are in existence: They are not as warm and loving as a family, but they do have a level of professional expertise that most families cannot provide. The home health agencies can help to bridge the gap while the general society recognizes and re-assumes its obligations to those who gave birth to the current society. We must make certain that there will continue to be a home health industry serving Medicare clients in the future. HCFA and the Fiscal Intermediaries seem to be doing all they can to damage this vital industry.

Just over a year ago, in late July and early August of 1986, Maine home health agencies were inundated by an unprecedented wave of denials. In the five years prior to July, 1986, CHCS had only exceeded the allowable 2.5% rate of denials for one month. It took one more month to bring the quarter's average back down below 2.5%, and, subsequently, many of the original denials were reversed. This clearly indicates that CHCS understood and complied with the existing eligibility and coverage criteria. Suddenly, at the beginning of fiscal year 1987, those services were no longer covered. HCFA admits that there was no legislative change and denies that there had been interpretive changes. I can assure you that we had not changed our procedures, so what could have caused this rash of denied services? At one point, the FI explained that they had possibly paid for inappropriate services in the past. If that is true, I cannot understand why HCFA chose Maine Blue Cross as the Region I Intermediary, even in the face of substantial opposition. I believe that it is clear that the interpretation of coverage criteria were changed without public notice in violation of the Administrative Procedures Act.

The impact of the changes in interpretation may be easily demonstrated: from July, 1986 through August, 1987, 243 clients were denied all or part of the services which CHCS had provided. As of October, 1987, 127 of these denials, or 52%, had been fully or partially reversed (no denials were received in September, 1987). The analysis of denied visits rather than denied clients is perhaps more informative because it can be more specific. During the period 10/1/86 through 9/30/87, six hundred ten (610) visits were denied. As of October, 1987, three hundred one (301) of these denied visits had already been reversed for a reversal rate of 49.3%. An analysis of the types of denials is even more fruitful, although it is complicated by HCFA's change of the reason codes structure in May, 1987. Of the 610 denied visits, 189 fell into two categories whose definitions are: "Visits not reasonable or medically necessary for the active care of the patient", and, "Number of visits not reasonable or medically necessary based on all available documentation". There are also two categories with the same definitions for Physical Therapy services. They appear to be the same category rather than two distinct categories, which should not be surprising since HCFA references the same regulation section for both (204.3). These reasons really boil down to the claim reviewer's opinion that the patient didn't really need these services. If we rephrase this type of denial in English, it translates as: the opinion of the reviewer, whose professional qualifications and skill level are unknown and who has never (in our case) been within 100 miles of the patient, is superior to the patient's own physician's opinion, who has given CHCS written and signed orders attesting to the medical necessity of this case. Given this situation, it is not at all surprising that our reversal rate on this type of denial is only 36.5%.

There is another denial category which is very similar to the one just discussed. It is defined as "Re-emphasis of teaching/training activities (204.2)". If we remember that 77% of our Medicare population is over 70 and 65% of the population live alone or with spouses of (probably) similar age, and 100% of the population is ill to the extent that physicians have ordered care for them, it is no great shock to learn that "re-emphasis of teaching/training activities" might be necessary. I presume Congress was not saying that the frail elderly must get it right and keep it right after one session. However, this same faceless reviewer who has never been near the patient decides that 100 of these visits were unnecessary, and our reversal rate is only 30%! I sometimes forget, when an antibiotic is prescribed, to take it one hour before meals, and I am not over seventy, ill enough to be homebound, and perhaps also taking a wide range of medications with different timings and requirements.

A third major group of denials are defined as: "Supportive to maintain patients in their home/activities of daily living, etc. (204.4 and 230)", and "Maintenance = PT, ST, OT services geared to maintain patient's functional level (205)". Please note that this is not the same as "Stable Condition", which is another category of denial. These patients are not stable patients, and intervention by a home health agency is intended to keep them from re-admission to a hospital or entry into a nursing home. I had thought that that was one of the prime reasons for covering home care for the elderly. This category was responsible for 62 denials, of which 54 were reversed, for an 87.1% reversal rate. This particular denial reason seems to have gone out of fashion, probably because of the reversal rate - only 11 have been received in the past 9 months.

The final category to be analyzed is a category which, prior to May 1, 1987, was defined as "Stable Condition". This definition might lead us to suspect that it was not well-defined and was, therefore, a catch-all for denials not covered elsewhere. On May 1, 1987, the definition was changed to "Extended visits for observation and assessment of a patient with a stable condition are not reasonable and necessary". It is important to note the change of definition since 150 denials and 101 reversals were received under the old definition, while only 1 denial (which was reversed) has been received under the newer, far more specific definition. The statistics imply that the older definition was really used as an equivalent to the reviewer's opinion of medically unnecessary, but was clearly less defensible by HCFA because the patient's condition could be objectively shown to be not stable through the use of vital sign measurements, intolerable pain levels, etc.

Because the remaining 62 unreversed denials fall into 32 potentially different codes, it is not statistically significant to analyse these denials.

We have already looked at 82.3% of the denials, and these denials all fall into what could be called "gray" areas. Forty-five (45) codes are currently in use by HCFA, 32 of which are quite specific and could possibly be considered objective in that two disinterested observers would reach the same conclusions from an examination of the patient. However, 82.3% of the denials received by CHCS fall into the 13 categories in which two equally skilled examiners might differ. In effect, the claims reviewer, whose qualifications are unknown and who is trained by an agent of HCFA (who has a vested interest in denying claims), is consistently allowed to deny care to patients they have never seen, but whose own doctors have filed written orders. And THESE CLAIMS REVIEWERS ARE ALLOWED TO DENY ON THE BASIS OF VAGUE AND UNSUBSTANTIATED FEELINGS THAT THE CARE IS NOT "MEDICALLY NECESSARY". The reviewer does not have to make a medical judgment which says: "Given the current observed condition of the patient, their age, complications of other illnesses, their living conditions, the support available at home, their mental state, and their economic condition, I prescribe the following as necessary...". The reviewer, who works for an agent of HCFA, only has to say: "I've never seen the patient; I don't know much about the general condition of the patient; but the physician who treated the patient doesn't know what he's talking about. This care is medically unnecessary". It is clear why the overwhelming number of denials fall into the soft, non-specific areas. And it is also clear why the attempt to reverse these denials is closely akin to attempting to nail a piece of Jello to the wall.

Denials do not appear to follow any consistent pattern. Rather, they seem to go through a period of heavy usage and then almost disappear if the reversal rate is high. CHCS has received very few Technical denials, although there was a rash of them in October, 1987. Judging by the past, this may signal the start of a new trend and a heightened effort by HCFA to once again remove us from a favorable waiver status. When an agency is off the waiver, denials are not paid for. Although this has some serious financial impact, the largest impact evolves from the overall diminution of services. This crisis struck so quickly and with such force that many agencies, ours included, became overly cautious in the delivery of service. Services that we had confidently delivered for years were being denied in large quantity, so that even the clearly covered cases were suspect. As our caseload dropped, we began cutting back on direct service workers, decreasing part-time utilization and putting some full-time employees on part-time status. Meanwhile, management and administrative personnel utilization was increasing in order to cope with the crisis. The amount of effort put into winning reversals, staff training, and processing demands for more information from the Fiscal Intermediary was truly phenomenal. Since we could not decrease our administrative costs, the same level of cost was being spread over 7,000 fewer Medicare visits. CHCS's nursing cost was over the caps for the first time. The net result was that our health services programs lost over $77,000 in fiscal year 1987. If we had just been over the caps in Medicare, the problem would have been less serious, but Medicare and Blue Cross both use the Medicare cost report for their settlements, and the three combined constitute over 90% of our home health business. With the permission of York County Health Services, we have included a copy of their correspondence with the National Association of Home Care's Center for Health Care Law. An attachment to this letter provides cost and visit statistics for four of the largest agencies in Maine (CHCS is identified as Agency 4).

One of the issues which is not readily apparent in the statistics from the four agencies is the cost of processing various HCFA paperwork requirements.

During the Summer of 1985, HCFA mandated the use of a new billing form called UB-82. At the same time, diagnostic coding was changed to ICD-9-CM. Immediately thereafter, in early Fall of 1985, the now infamous 485, 486, 487 Plan of Care was implemented by HCFA with little prior consultation by the home health industry. We did not keep specific figures on the ICD-9 coding change, but the billing form and the plan of care used over 3,500 hours of staff time for design, programming, and implementation training. In addition, it was necessary for us to hire an additional data entry person to do the processing of the plans of care. We have also had to add one data station for the new operator and an additional data station to absorb extra workload on peak days. Perhaps this new automation would have eased the paperwork burden on direct service personnel, but, even with the automation, it still takes an RN longer to fill out the new plan of care than it took to do the old one. Consequently, direct care time is down, paperwork time is up, there is an increase in administrative cost due to the new data entry position and the new data processing equipment, so the cost per unit of service has to go up. The first year design costs averaged over the number of visits for 1986 came to an increase of over one dollar per visit. There was no increase in the cost limit in 1986 to allow for this.

The ongoing cost in additional personnel and equipment alone is over 50 cents per visit, but this does not take into account the general increase in administrative time and the significant extra cost due to lost productivity. HCFA supposedly took this into account in their re-calculation of the 1987 cost limits and awarded a whopping 37 cents add-on to "cover" the cost. Clearly, HCFA needs to be far more realistic with their cost estimating.

The tremendous and unprecedented increase in denials to Medicare beneficiaries also had several significant negative effects on health care professionals and the Agency, Community Health and Counseling Services.

One critical area affected was that of clinical practice. Traditionally, health professionals have been educated to assess the need for the plan of care, implement the process and evaluate the outcome of health services indicated for each individual client.

Health care professionals now feel frustrated and professionally compromised in working with the Medicare system. They find themselves in a position of playing word games in order to provide their frail elderly clients with the care they critically need. Hours are spent in masses of paperwork - time that clinicians believe should be spent with clients.

It is as obvious to the direct service clinician as to the administration that the abundance of required paperwork must be driving costs up at the same time that attempts to reduce Medicare expenditures are resulting in less service to the client. Surely this was not the intent of Congress. Even prior to the new and additional paperwork requirement, HCFA was judged by the Office of Management and Budget (OMB) to be out of compliance with the Paperwork Reduction Act in its requirements of home health providers as reported in a national trade publication.

A concern of agency management in this process was that the health care professional would become a victim of Medicare's behavior modification attempts and would start looking at client needs and client care only to the extent of Medicare reimbursement. The result would be an increased number of frail elderly going without the care they need or at best having their needs only partially met. To hopefully combat this self denial process, reeducation focused on documentation semantics rather than new definitions of covered services. Regardless, staff behavior seems to have been modified by the rush of denials.

Another effect has been an increase in staff stress and staff demoralization. The necessity of becoming reimbursement specialists increased staff stress. A continuing high level of denials for services rendered as much as eighteen months earlier increased staff stress. The decrêase in new admissions and in number of visits to existing clients decreased the need for staff and led to decreased work for both full and part time staff, which led, in turn, to even more stress on staff. A work environment exists in which there is less time than ever to care for clients, less job satisfaction, thus a decrease in staff morale.

In an amazingly short period of time, all of these negative reinforcements did result in a behavioral change in which CHCS was denying (actually self-denying) as many services as the intermediary was denying. The CHCS financial statements for the period ending June 30, 1987 revealed a year to date deficit of more than $77,000 in the home health program. The major cause of this insupportable and unprecedented loss was the fact that the agency's cost per visit for skilled nursing services was over the caps for the first time since the inception of the caps in 1979, and its home health aide costs were dangeriously close to the caps. Although this situation was certainly unwelcome, it was far from unexpected. The increased administrative and direct service paperwork burden was not only coupled with the denial problem, but both problems were compounded by the fact that the caps themselves were unrealistically low. The FY 87 caps were computed using 1982 hospital wage survey data and 1983 home health cost data. These costs were then trended forward for inflation, but they were not adjusted to reflect the impact of prospective payment in hospitals or the increasing regulatory paperwork burdens imposed since 1983. Trending forward for inflation has absolutely no mitigating effect on costly program changes, especially changes whose greatest impact is on productivity.

Thus the circle began to close - new regulatory interpretations cut into the number of eligible clients at a time when paperwork burdens had already increased costs and decreased productive time. This led to financial instability for the agency and decreased job security for staff, which heightened staff stress and decreased staff morale.

Many administrative initiatives have been implemented to combat these serious issues; yet the future of the Medicare system continues to appear tenuous and the plight of the elderly still in jeopardy. The cost to our agency in terms of documentation demands, cash flow and staff turnover remains unclear.

Our agency does not have a large endowment or extensive fund raising effort. The financial stability of our agency is in part dependent upon PIP (Provider Interim Payments). It has been brought to our attention by Blue Cross Blue Shield of Maine that HCFA now wants a "consistent application" of PIP. Dave Garland of Blue Cross Blue Shield referred the agencies to HIM 15, Chapter 24. He stated that Blue Cross Blue Shield was waiting for guidelines from Region 1. He stated that this change would not be a rule or regulation change, but a change in interpretation. Is this the second assault on Home Health in Maine?

We urge your support in resolving this critical issue. Congress needs to regain control of the Medicare program and curtail HCFA's unauthorized redefining of the benefits.

York
County
Health
Services
Industrial Park Road,
RFD 1, Box 15A, Saco Maine 04072
[illegible]

October 26, 1987

William Dombi, Esquire
National Association for Home Care
519 C Street, NE
Washington, DC 20002

Dear Bill:

The lawsuit which Region I Home Health Agencies and the Center for Health Care Law intends to file against Maine Blue Cross/Blue Shield (MEBC/BS) as the Fiscal Intermediary for Region I is extremely important to the elderly of Maine.

I have compiled the attached information from the four largest agencies in Maine that have completed their first fiscal year under the new regime at Blue Cross.

Maine agencies were the first to feel the effects of the transfer in July 1986 when MEBC/BS began to "practice" behavior modification thru denial and "re-education" on the Maine agencies.

During the July thru September 1986 quarter, Maine agencies (which had never been off waiver before) were hit with an onslaught of denials and denial rates up to 25%. The denials excelled during the October - December 1986 quarter with denial rates topping 37%. The extraordinary denial rates were compounded by the dramatic cutbacks in Medicare services delivered.

Staff was demoralized and internalized the unprecedented number of denials, dramatically decreasing Medicare visits, not accepting Medicare patients and discharging prematurely. (York County Health Services experienced a 67% reduction in Medicare visits comparing July 86 with November 86.)

MEBC/BS was helpful in reinforcing this reactive phase by providing continuing on-site,"re-education" classes, encouraging staff to believe that the Medicare services they had delivered for the past ten or more years were not covered by Medicare.

The attached information, we believe, helps to substantiate the claim that the elderly of Maine have gone without needed Medicare covered services by showing the following effects of the first year after transition.

1. A decrease in Medicare visits of 18,483V or 26.03%.
2. A decrease in Medicare patients served of 706P or 16%.
3. A decrease in Medicare visits/patients of 1.92V/P or 11.94%.
4. An increase in total cost of services of $71,281 or 1.15%.
   To provide
5. a decrease (due to Medicare) of total services of $16,020 visits or 9.95%.
   Causing
6. an increase in average cost/visit of $4.76/V or 12.32%.

This information was taken from Cost Reports as filed for FY86 (July 1, 1985 - June 30, 1986) prior to transition and FY87 (July 1, 1986 - June 30, 1987) after transition for York County Health Services, Saco; Community Health Services, Portland; Kennebec Valley Regional Health, Augusta/Waterville; and Community Health Counseling Services, Bangor.

I hope that this information is helpful in making a case against MEBC/BS for the irreparable harm they have caused to the elderly of Maine by threatening the survival of Home Health Agencies in Maine.

Please contact me at any time if you need clarification of the information enclosed or further information compiled. We look forward with anticipation to your assistance in stopping MEBC/BS and restoring the Medicare Benefit for the elderly.

Very truly yours,

Kathleen B Tauro

Kathleen B. Tauro
Director of Business & Finance

KBT/dc

cc: Linda Billows

Attach.

Cost/Visit Comparison for Maine Agencies
Since Transfer to New FI

	FY86	FY87	FY86	FY87	FY86	FY87	FY86	FY87	FY86	FY87	
	AGENCY 1		AGENCY 2		AGENCY 3		AGENCY 4		— TOTAL —		
	Program Cost		Program Cost		Program Cost		Program Cost		Program Cost		% Change
Skilled Nursing	680012	509678	1161305	1230506	729088	953244	979381	924331	3549786	3617759	1.91%
Physical Therapy	239709	268061	394880	359752	201903	215329	171530	135333	1008022	978475	-2.93%
Occupational Ther.	78823	91849	52506	77294	34473	37793			165802	206936	24.81%
Speech Pathology	44674	15534	56531	57296	12836	9047	6049	5173	120090	87050	-27.51%
Med. Social Service	30559	37226		7248	499	1755	3362	1581	34420	47810	38.90%
Home Health Aide	298470	382607	503407	414335	199380	244556	338070	309200	1339327	1350698	0.85%
Total	1372247	1304955	2168629	2146431	1178179	1461724	1498392	1375618	6217447	6288728	1.15%
	Program Visits		Program Visits		Program Visits		Program Visits		Program Visits		
Skilled Nursing	12903	10146	26207	20784	18117	21795	19811	16655	77038	69380	-9.94%
Physical Therapy	5034	4820	9078	7195	3978	4187	2855	1984	20945	18186	-13.17%
Occupational Ther.	1295	1229	1309	835	576	416			3180	2480	-22.01%
Speech Pathology	726	267	1161	1120	229	195	91	62	2207	1644	-25.51%
Med. Social Service	305	433		82	8	49	36	34	349	598	71.35%
Home Health Aide	11323	12620	23174	17352	9871	11012	12941	11736	57309	52720	-8.01%
Total	31586	29515	60929	47368	32779	37654	35734	30471	161028	145008	-9.95%
	Cost per Visit		Cost per Visit		Cost per Visit		Cost per Visit		Cost per Visit		
Skilled Nursing	52.70	50.23	44.31	59.20	40.24	43.74	49.44	55.50	46.08	52.14	13.16%
Physical Therapy	47.62	55.61	43.50	50.00	50.75	51.43	60.08	68.21	48.13	53.80	11.80%
Occupational Ther.	60.87	74.73	40.11	92.57	59.85	90.85			52.14	83.44	60.04%
Speech Pathology	61.53	58.18	48.69	51.16	56.05	46.39	66.47	83.44	54.41	52.95	-2.69%
Med. Social Service	100.19	85.97		88.39	62.38	35.82	93.39	46.50	98.62	79.95	-18.94%
Home Health Aide	26.36	30.32	21.72	23.88	20.20	22.21	26.12	26.35	23.37	25.62	9.63%
Total	43.44	44.21	35.59	45.31	35.94	38.82	41.93	45.15	38.61	43.37	12.32%

	Medicare Visits		Medicare Visits		Medicare Visits		Medicare Visits		Medicare Visits		
Skilled Nursing	6403	4091	10488	7175	5747	5689	11782	7888	34420	24843	-27.82%
Physical Therapy	2835	2328	5992	4573	2997	3144	2287	1281	14111	11326	-19.74%
Occupational Ther.	411	218	398	283	194	113			1003	614	-38.78%
Speech Pathology	339	103	776	796	132	142	59	54	1306	1095	-16.16%
Med. Social Service	129	74		14		17	10	18	139	123	-11.51%
Home Health Aide	4371	3147	5934	4213	3179	2731	6538	4426	20022	14517	-27.49%
TOTAL	14488	9961	23588	17054	12249	11836	20676	13667	71001	52518	-26.03%

	Medicare Patients		Medicare Patients		Medicare Patients		Medicare Patients		Medicare Patients		
Skilled Nursing	686	518	1227	984	507	514	987	816	3407	2832	-16.88%
Physical Therapy	343	306	630	585	426	271	226	176	1625	1338	-17.66%
Occupational Ther.	60	48	92	39	32	28			184	115	-37.50%
Speech Pathology	25	13	38	89	13	6	2	11	78	119	52.56%
Med. Social Service	43	40		10		8	3	8	46	66	43.48%
Home Health Aide	297	220	540	382	181	164	370	274	1388	1040	-25.07%
TOTAL	925	746	1537	1328	855	706	1095	926	4412	3706	-16.00%

	Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		
Skilled Nursing	9.33	7.90	8.55	7.29	11.34	11.07	11.94	9.67	10.10	8.77	-13.17%
Physical Therapy	8.27	7.61	9.51	7.82	7.04	11.60	10.12	7.28	8.68	8.46	-2.52%
Occupational Ther.	6.85	4.54	4.33	7.26	6.06	4.04			5.45	5.34	-2.05%
Speech Pathology	13.56	7.92	20.42	8.94	10.15	23.67	29.50	4.91	16.74	9.20	-45.04%
Med. Social Service	3.00	1.85		1.40		2.13	3.33	2.25	3.02	1.86	-38.33%
Home Health Aide	14.72	14.30	10.99	11.03	17.56	16.65	17.67	16.15	14.43	13.96	-3.23%
TOTAL	15.66	13.35	15.35	12.84	14.33	16.76	18.88	14.76	16.09	14.17	-11.94%

Notes: FY86 includes period from 07/01/85 thru 06/30/86
FY87 includes period from 07/01/86 thru 06/30/87

TESTIMONY

Senator Mitchell, Senator Cohen, I'm Linda Billows, Region I Director for the National Association For Home Care. I represent the New England States on the Board of our National Association. There are approximately 350 members of the National Association For Home Care in Region I and over 5,000 members in the nation. I would like to thank you for holding this hearing today so I can express to you the grave concern with the current Medicare denial crisis in Region I. I would also like to thank you for all the work you have done on behalf of home health agencies in codifying Medicare Home Health Regulations.

There are currently 305 certified home health agencies in Region I who bill Blue Cross of Maine for their Medicare patients. The nature of the problems being experienced in Region I include:

- High denial rate coupled with the fact that denials seem arbitrary and capricious
- Delays in re-openings and re-considerations
- Lack of responsiveness
- The use of unqualified staff to make decisions overruling physicians orders

The problems with medical necessity denials is the greatest concern in our Region. The denial crisis is devastating; devastating to the patient, the staff that cares for them, and the agencies.

The crisis is not just a few agencies or any one state. Agencies, state associations, and the National Association For Home Care have collected data to substantiate the severity of the problem. The data I share with you has been submitted to the National Association For Home Care to quantify the avalanche of denials and the chilling effect on agencies.

From Maine, an 86 year old man was admitted to a home health agency after surgery for a bowel obstruction. The initial orders from the physician included a nursing visit every other day to change the dressing applied to an 8 inch incision on the patient's abdomen. At the time of admission, it was observed that the patient was extremely weak post hospitalization, was experiencing abdominal pain, was experiencing shortness of breath and spending most of his time in bed. The patient's spouse suffered from Alzeheimer's disease. Blue Cross of Maine denied all but 2 visits a week.

From Massachusetts, a women who had a mass excised on her left breast was admitted to a home health agency for wound care. The wound was red, black and blue, swollen and very tender. The mass proved to be malignant. The patient was re-hospitalized for a mastectomy and the patient returned home again for wound care. She required skilled nursing visits to change her dressing, teach her wound care, teach the signs and symptoms of infection, and exercises for her left upper arm. Once again an arbitrary denial of the number of medically necessary visits was made by Blue Cross of Maine.

From New Hampshire, a woman was admitted to a home health agency post-hospitalization for pneumonia and chronic obstructive pulmonary disease. The patient had an elevated temperature, an irregular pulse, was congested and was experiencing shortness of breath on exertion. An apparently random selection of 3 visits were determined to be not medically necessary.

From Vermont, a woman admitted post hospital stay for chronic obstructive pulmonary disease and congestive heart failure. Skilled nursing visits once a week were felt appropriate to monitor the patient's respiratory and cardiac status. The patient required teaching in how to use her inhalator.and oxygen and instructions regarding change in medications. The patient was extremely weak with shortness of breath. Certification period submitted to Blue Cross of Maine was May 7, through July 7, 1987. There was an arbitrary decision by Blue Cross of Maine to deny 4 of the 7 visits. The patient expired June 21, 1987.

I would also like to share with you some letters from our agencies on the chilling effect of the crisis:

"Maine agencies were the first to feel the effects of the transfer in July of 1986, to Maine Blue Cross when Maine Blue Cross began to practice behavior modifications through denials and re-education of the Maine agencies. I have compiled the following information from the 4 largest agencies in Maine who have completed their first fiscal year under the new regime. During the July through September, 1986, quarter, Maine agencies, which had never been off waiver, were hit with an onslaught of denials and denial rates up to 25%. It is now accelerated during the October to December 1986, quarter with denial rates topping 37%. The extraordinary denials were compounded by the dramatic cut-backs in Medicare service delivered. Staff was demoralized and internalized the unprecedent number of denials dramatically decreasing Medicare visits.

I hope the following information helps to substantiate the claim that the elderly of Maine have gone without needed Medicare covered services by showing the effects in the first year after transition. (See attachment)

1) A decrease in Medicare visits of 26%
2) A decrease in Medicare patients served by 16%
3) A decrease in Medicare visits per patient by 11.9%
4) An increase in total cost of service of $71,000
5) An increase in average cost per visit of 12%

This information was taken from cost reports filed fiscal year 1986, prior to the transition in fiscal year 1987."

From Rhode Island, "the Visiting Nurse Service is a Medicare certified home health agency that had experienced only 1 Medicare denial in its entire 20 year history. We transferred to Maine Blue Cross on January 1, 1987, and the denials began to arrive at that agency in mid-March 1987. Almost one quarter of all of our claims for January 1987, were denied. To date, we have been successful in over-turning about one third of our denials in the first stage of appeal. Over 50% of the cases initially denied were over-turned in re-openings. We have yet to hear of any claims sent to the second stage of appeal or re-consideration. The number of visits billed per month to Medicare has decreased 37% and the number of beneficiaries served per month under Medicare has decreased 26%. We estimate that we have lost over $120,000 through August. Obviously, this has resulted in a significant financial burden on our agency. The problem becomes more critical since it puts an additional drain on funds we have available to subsidize care for those who are unable to pay for this service. This will require a cut-back in the amount of service we can provide unless we can receive additional funding in the next year."

"In addition, I would like to outline other problems:

1) Excessive time delays in Maine regarding the appeal process
2) Errors made in denial notices
3) Extremely unclear wording of denial notices and errors made in counting visits in our waiver of liability calculation"

For Massachusetts, "the impact of Medicare denials on our patients and on our agency has been substantial. Our agency prior to 1984, was providing 47,000 visits per year. We are now providing 27,000 visits. I believe this loss of visits is the increased Medicare denial system or the fear of it. We find staff who fear providing service because of their concern for denials. These capricious denials have instilled a great deal of uneasyness in our staff no matter how much education we provide. Financial impact necessitated a cut-back in staff. The poorly constructed denial system has substantially increased the cost of a home care visit. Because of this system, we have approximately 2½ staff that spend full-time on Medicare 485's, 488's and training our staff in documentation."

In the current months of July and August, our denials are running $5,000 to $7,000 per month. In a private, non-profit agency with little surplus you can see that without a turn-around system we will be out of business in a very short time. The threat of bankruptcy remains ever present. If an agency provides care in good faith in accordance with regulations and then is retroactively denied, who can tolerate this loss on an ongoing basis. It is completely unpredictable. Give us the rules please, so that we can follow them. Denials are subjective and irrationale."

Again, I stress that this documentaiton represents but a sample of what we have collected throughout the region to document the harm done by the Medicare denial crisis. I'm sure if I were listening to these tales, I would ask what have the agencies done to communicate with Blue Cross of Maine and the Health Care Financing Administration Region I office and how have they tried to resolve these problems.

In May, 1985, the home health agencies in New England began meeting on a regional basis surrounding the transfer to the regional intermediary. The goal of our group, which has been meeting for 31 months, was to maximize communication and facilitate a good relationship with Blue Cross of Maine. It was our intent to establish regular meetings with the intermediary so that issues could be discussed in advance of their becoming problems. We've met more than a dozen times as a regional group with Blue Cross of Maine. Health Care Financing Administration representatives were present at a majority of these meetings. In addition to that, state associations have coordinated educational programs in all the New England States and individual agencies have coordinated internal educational programs. The issues identified well over a year ago continue to be problems.

In review of minutes of all our meetings again in April this year, the problems remained:

1) Denials
2) Delays in re-openings
3) Lack of timely issuing of denial letters

Linda Billows, Region I

4) Timely response to policy questions
5) Lack of clarity and completeness of MEDI-MESSAGES
6) Inadequate staffing in raw numbers, training, and performance
7) Accuracy of waiver of liability calculations

The only change in over a year is a change in the type of denials from technical denials to medical necessity denials.

A typical sequence of events in the claims processing period which might be helpful, and I'll take one from my own agency, is as follows:

1) Patient was admitted for home health services on March 8th
2) Period of service was March 8, through March 31, 1987
3) The bill was submitted to Blue Cross of Maine on April 16, 1987
4) Denial was received by the agency July, 1987
5) Submission for appeal in August, 1987
6) To date, we have not received any response

In closing, I would like to thank you on behalf of the elders we serve and the agencies I represent. Agencies in Region I can not continue to weather the onslaught of this Medicare Denial Storm. Clients are not getting Medicare coverage for visits to which they are entitled. Agencies are continuing to provide service while watching deficits grow. It would be a cruel irony of life if agencies go out of business while trying to advocate on behalf of the clients they serve. Who then will provide the needed home health care?

Cost/Visit Comparison for Maine Agencies
Since Transfer to New FI

	FY86	FY87	FY86	FY87	FY86	FY87	FY86	FY87	FY86	FY87	
	— YCHS —		— CHS —		— KVRH —		— CH&CS —		— TOTAL —		
	Program Cost		Program Cost		Program Cost		Program Cost		Program Cost		% Change
Skilled Nursing	680012	509678	1161305	1230506	729088	953244	979381	924331	3549786	3617759	1.91%
Physical Therapy	239709	268061	394880	359752	201903	215329	171530	135333	1008022	978475	-2.93%
Occupational Ther.	78823	91849	52506	77294	34473	37793			165802	206936	24.81%
Speech Pathology	44674	15534	56531	57296	12836	9047	6049	5173	120090	87050	-27.51%
Med. Social Service	30559	37226		7248	499	1755	3362	1581	34420	47810	38.90%
Home Health Aide	298470	382607	503407	414335	199380	244556	338070	309200	1339327	1350698	0.85%
Total	1372247	1304955	2168629	2146431	1178179	1461724	1498392	1375618	6217447	6288728	1.15%
	Program Visits		Program Visits		Program Visits		Program Visits		Program Visits		
Skilled Nursing	12903	10146	26207	20784	18117	21795	19811	16655	77038	69380	-9.94%
Physical Therapy	5034	4820	9078	7195	3978	4187	2855	1984	20945	18186	-13.17%
Occupational Ther.	1295	1229	1309	835	576	416			3180	2480	-22.01%
Speech Pathology	726	267	1161	1120	229	195	91	62	2207	1644	-25.51%
Med. Social Service	305	433		82	8	49	36	34	349	598	71.35%
Home Health Aide	11323	12620	23174	17352	9871	11012	12941	11736	57309	52720	-8.01%
Total	31586	29515	60929	47368	32779	37654	35734	30471	161028	145008	-9.95%
	Cost per Visit		Cost per Visit		Cost per Visit		Cost per Visit		Cost per Visit		
Skilled Nursing	52.70	50.23	44.31	59.20	40.24	43.74	49.44	55.50	46.08	52.14	13.16%
Physical Therapy	47.62	55.61	43.50	50.00	50.75	51.43	60.08	68.21	48.13	53.80	11.80%
Occupational Ther.	60.87	74.73	40.11	92.57	59.85	90.85			52.14	83.44	60.04%
Speech Pathology	61.53	58.18	48.69	51.16	56.05	46.39	66.47	83.44	54.41	52.95	-2.69%
Med. Social Service	100.19	85.97		88.39	62.38	35.82	93.39	46.50	98.62	79.95	-18.94%
Home Health Aide	26.36	30.32	21.72	23.88	20.20	22.21	26.12	26.35	23.37	25.62	9.63%
Total	43.44	44.21	35.59	45.31	35.94	38.82	41.93	45.15	38.61	43.37	12.32%

	Medicare Visits		Medicare Visits		Medicare Visits		Medicare Visits		Medicare Visits		
Skilled Nursing	6403	4091	10488	7175	5747	5689	11782	7888	34420	24843	-27.82%
Physical Therapy	2835	2328	5992	4573	2997	3144	2287	1281	14111	11326	-19.74%
Occupational Ther.	411	218	398	283	194	113			1003	614	-38.78%
Speech Pathology	339	103	776	796	132	142	59	54	1306	1095	-16.16%
Med. Social Service	129	74		14		17	10	18	139	123	-11.51%
Home Health Aide	4371	3147	5934	4213	3179	2731	6538	4426	20022	14517	-27.49%
TOTAL	14498	9961	23588	17054	12249	11836	20676	13667	71001	52518	-26.03%
	Medicare Patients		Medicare Patients		Medicare Patients		Medicare Patients		Medicare Patients		
Skilled Nursing	686	518	1227	984	507	514	987	816	3407	2832	-16.88%
Physical Therapy	343	306	630	585	426	271	226	176	1625	1338	-17.66%
Occupational Ther.	60	48	92	39	32	28			184	115	-37.50%
Speech Pathology	25	13	38	89	13	6	2	11	78	119	52.56%
Med. Social Service	43	40		10		8	3	8	46	66	43.48%
Home Health Aide	297	220	540	382	181	164	370	274	1388	1040	-25.07%
TOTAL	925	746	1537	1328	855	706	1095	926	4412	3706	-16.00%
	Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		Medicare Vis/Pat		
Skilled Nursing	9.33	7.90	8.55	7.29	11.34	11.07	11.94	9.67	10.10	8.77	-13.17%
Physical Therapy	8.27	7.61	9.51	7.82	7.04	11.60	10.12	7.28	8.68	8.46	-2.52%
Occupational Ther.	6.85	4.54	4.33	7.26	6.06	4.04			5.45	5.34	-2.05%
Speech Pathology	13.56	7.92	20.42	8.94	10.15	23.67	29.50	4.91	16.74	9.20	-45.04%
Med. Social Service	3.00	1.85		1.40		2.13	3.33	2.25	3.02	1.86	-38.33%
Home Health Aide	14.72	14.30	10.99	11.03	17.56	16.65	17.67	16.15	14.43	13.96	-3.23%
TOTAL	15.66	13.35	15.35	12.84	14.33	16.76	18.88	14.76	16.09	14.17	-11.94%

Notes: FY86 includes period from 07/01/85 thru 06/30/86
FY87 includes period from 07/01/86 thru 06/30/87

Good morning Senator Cohen and Senator Mitchell. I am William R. Johnson, President of Blue Cross and Blue Shield of Maine. Thank you for the invitation to present testimony today on the Medicare Home Care Program and to discuss our role as fiscal intermediary.

BACKGROUND: As you both are aware, Blue Cross has served as the fiscal intermediary for Part A of the Medicare program in Maine since the inception of the program more than twenty years ago. On the basis of our performance, we were selected by the Health Care Financing Administration (HCFA) to serve as the fiscal intermediary of the Medicare Home Health Benefit for New England (Region I), and began operation of the project in the fall of 1986.

FISCAL INTERMEDIARY ROLE: As fiscal intermediary we are responsible for the administration of the Medicare Home Care Program in New England within the framework of the contract we have entered into with HCFA. Our principal responsibilities can be placed into three broad areas:

1. Process claims received from providers in a timely manner,
2. Make benefit determinations that are consistent with the Medicare regulations as set forth by the federal government, and
3. Audit provider financial records to ensure that providers are appropriately reimbursed for services provided.

PHILOSOPHY: Home Health Care is an industry that has existed for generations. Many of the agencies Blue Cross serves in Region I can boast over one hundred years of caring services in their communities. It is the expectation and right of every Medicare beneficiary that Home Care services will be available no matter where he or she resides and that Home Care services will be delivered in a responsive, efficient, safe and cost effective manner.

It is our belief that as a fiscal intermediary we have a prime responsibility to the Medicare beneficiaries who receive home care, to the providers who deliver home care and to the government who administers the Home Care Program...that prime responsibility is to ensure a program that carries out the intent of the Medicare law as interpreted by the HCFA rules, regulations and guidelines under which we operate. As fiscal intermediary our goal is to operate from the basic assurance that beneficiaries are receiving their entitled services, that we are making accurate and valid medical review determinations and that HCFA contracts are appropriately fulfilled.

TRANSITION: The past year has been one of transition for us as well as for the home health agencies. To assist you in comprehending the magnitude of this transition workload, I would like to share a few statistics with you.

.. We have grown from serving 16 home health agencies to serving 305.

.. Our claims volume ran approximately 25,000 claims a year prior to 1986. We expect to process 23,000 claims a month in 1988.

.. The dollar volume of the claims a year ago was close to $6 million. For 1988, we project that volume will be around $100 million.

In order to have this transition proceed as smoothly as possible, Blue Cross has accomplished a number of tasks in the past twelve months.

.. A staff of more than 70 people has been recruited, hired and trained for this program. Only professional registered nurses (most of whom have extensive experience in the field of home health), a registered physical therapist and a consulting physician make medical review determinations.

.. Over 250 meetings have been held with home health agencies to educate their staff and to respond to provider questions.

.. A Provider Relations Department has been established consisting of professional nurses with excellent qualifications. These staff members, located throughout the region, are available to visit agency staff on site and to conduct educational sessions primarily directed toward improving the provider's knowledge of the billing process and documentation requirements.

.. A toll-free 800 telephone line has been set-up to provide immediate access to our staff.

DENIALS: Statements have been made that Maine has had the highest denial rate in the country. We believe this to be inaccurate. National denial statistics prepared by HCFA (Exhibit #1) show that Region I had the lowest ...4.8%...denial rate in the country for the quarter ending June 30, 1987. In additional, we have reviewed our regional and state data for the first three quarters of 1987. I am pleased that it shows a definite trend of steady and marked improvement in performance and claim denials to the point where in the third quarter ending September 30th, the denial rate in Maine - Senators - is less than 1%. And, all Maine home health agencies currently have favorable waiver status.

In response to your specific questions relative to types of denials, I would note that most denials are based on Medical Necessity. Denials for the Homebound in Maine have been and continue to be extremely low.

AUDIT: In an attempt to determine if Blue Cross and Blue Shield of Maine has been properly administering the Home Health Benefit I recently requested that the regional HCFA office come to Maine and evaluate our performance. That review by HCFA which I received October 25th, indicates "you have planned well, hired qualified and talented staff; put in place appropriate internal management controls, and have passed HCFA standards in relationship to Medical Review".

We took the additional initiative of engaging the reputable accounting firm of Ernst & Whinney to perform an independent audit of the program. From the copies I have shared with you, you will note that Ernst & Whinney has told us that, "we are ninety-five percent confident that Blue Cross and Blue Shield personnel made an appropriate initial approval or denial decision for ninety percent or more of all Home Health claims". Also, their analysis for a five month period ending in August, indicated that the estimated error rate for claims when measured on a visits reviewed basis, was less than three percent.

Finally, we believe we have done everything in our power to operate this program correctly...within the guidelines established by our contract with HCFA.

Summary: As fiscal intermediary our ability to make changes to policies or procedures is very limited. However, we welcome your proposals or suggestions as to how we can improve our operation. I think the tasks which Blue Cross and Blue Shield of Maine has accomplished in the last twelve months demonstrate our willingness to carry-out a critical responsibility in the best possible manner.

We look forward to working with all interested parties to continue this vital program.

Thank You.

DEPARTMENT OF HEALTH & HUMAN SERVICES

STATEMENT OF
JOHN D. KENNEDY
REGIONAL ADMINISTRATOR
REGION I
HEALTH CARE FINANCING ADMINISTRATION
ON
FINANCING AND DELIVERY OF HOME HEALTH CARE
PORTLAND, MAINE

NOVEMBER 16, 1987

SENATORS MITCHELL AND COHEN, I AM JOHN D. KENNEDY, REGIONAL ADMINISTRATOR FOR THE HEALTH CARE FINANCING ADMINISTRATION. I AM PLEASED TO BE HERE TODAY TO SPEAK ABOUT THE MEDICARE PROGRAM'S ROLE IN FINANCING HOME HEALTH CARE SERVICES FOR THE ELDERLY.

BACKGROUND

LET ME BEGIN BY BRIEFLY DESCRIBING THE MEDICARE HOME HEALTH BENEFIT. THE MEDICARE HOME HEALTH BENEFIT IS VIEWED AS AN ESSENTIAL COMPONENT OF THE MEDICARE BENEFIT PACKAGE. HOME HEALTH CARE IS OFTEN THE FINAL STAGE OF A PATIENT'S RECOVERY PROCESS FROM AN ACUTE ILLNESS -- A PERIOD WHERE THE PATIENT STILL REQUIRES SOME SKILLED CARE BUT GENERALLY NOT ON A DAILY BASIS. TO RECEIVE MEDICARE HOME HEALTH SERVICES, A BENEFICIARY MUST BE UNDER A PHYSICIAN'S CARE, HAVE A NEED FOR SKILLED CARE AND BE HOMEBOUND. WHEN THESE CONDITIONS ARE MET, PATIENTS CAN RECEIVE INTERMITTENT OR PART-TIME SKILLED NURSING AND NURSING AID SERVICES, PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY, THE SERVICES OF A MEDICAL SOCIAL WORKER, AND MEDICAL SUPPLIES AND EQUIPMENT. MEDICARE PATIENTS CAN ALSO RECEIVE DAILY NURSING CARE IN THEIR HOME FOR UP TO 3 WEEKS, AND BEYOND IN UNUSUAL CIRCUMSTANCES, IF THEIR PHYSICIAN CERTIFIES THAT THE NEED FOR DAILY CARE WILL NOT CONTINUE INDEFINITELY.

THE HOME HEALTH BENEFIT IS ONE OF THE FASTEST GROWING COMPONENTS OF THE MEDICARE PROGRAM AND MORE MEDICARE BENEFICIARIES ARE RECEIVING HOME CARE THAN EVER BEFORE. IN FY 1986 OVER 38

MILLION HOME VISITS WERE MADE TO 1.5 MILLION BENEFICIARIES; OVER 1.9 MILLION OF THESE HOME HEALTH VISITS WERE MADE TO MEDICARE BENEFICIARIES IN NEW ENGLAND - APPROXIMATELY 153,000 OF WHICH WERE MADE TO MAINE BENEFICIARIES. SINCE 1981, THE NUMBER OF HOME HEALTH AGENCIES CERTIFIED TO PROVIDE CARE HAS DOUBLED TO ALMOST 6,000 TODAY. SINCE 1980, MEDICARE HOME HEALTH SPENDING HAS TRIPLED NATIONALLY TO OVER $2.5 BILLION IN FY 1986. IN NEW ENGLAND, MEDICARE HOME HEALTH SPENDING HAS INCREASED FROM OVER $60 MILLION IN 1981 TO MORE THAN $289 MILLION IN FY 1987.

LET ME ALSO MENTION THAT THE MEDICAID PROGRAM, ADMINISTERED JOINTLY BY THE STATES AND THE FEDERAL GOVERNMENT THROUGH THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), ALSO PROVIDES MOST OF THE SAME SERVICES AS MEDICARE. IN ADDITION, A STATE CAN OPT TO PROVIDE PERSONAL CARE SERVICES TO RECIPIENTS IN THEIR HOMES, A BENEFIT GEARED TO INDIVIDUALS WITH FEWER MEDICAL NEEDS THAN HOME HEALTH PATIENTS BUT WHO NEED SOME ASSISTANCE TO REMAIN IN THE HOME. BECAUSE OF THIS FEATURE, MEDICAID GENERALLY PROVIDES HOME HEALTH CARE OF A LONGER DURATION THAN THE MEDICARE BENEFIT WHICH IS MOST FREQUENTLY LINKED TO POST-ACUTE CARE.

MEDICAID SERVICES PROVIDED IN THE HOME HAVE MADE IMPORTANT CONTRIBUTIONS TO OUR SENIOR CITIZENS. SINCE 1981, THE MEDICAID PROGRAM HAS PROVIDED STATES WITH A MECHANISM TO TARGET HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC GROUPS OF RECIPIENTS. IN MAINE, THE STATE HAS DESIGNED SEVERAL INNOVATIVE AND COST-EFFECTIVE PROGRAMS TO ASSIST MANY ELDERLY AND PHYSICALLY

DISABLED MEDICAID RECIPIENTS, WHO WOULD OTHERWISE BE IN NURSING HOMES. MAINE IS CURRENTLY OPERATING TWO PROGRAMS WHICH PROVIDE HOMEMAKER, ADULT DAY HEALTH, CASE MANAGEMENT, PERSONAL CARE AND RESPITE CARE SERVICES NOT OTHERWISE COVERED BY MEDICAID. IN FY 1986, THESE PROGRAMS SERVED CLOSE TO 850 MAINE RESIDENTS AT A COST OF NEARLY $3 MILLION DOLLARS. IN ADDITION, ALMOST 5,000 MAINE RESIDENTS RECEIVED HOME HEALTH SERVICES COVERED UNDER THE STATE MEDICAID PLAN AT A COST OF APPROXIMATELY $7 MILLION DOLLARS.

QUALITY ACTIVITIES

THE DRAMATIC GROWTH IN THE USE OF HOME HEALTH SERVICES REFLECTS CHANGES THAT WILL CONTINUE, GIVEN THE CURRENT EMPHASIS ON EFFICIENT USE OF HOSPITAL RESOURCES AND THE INCREASED MEDICAL AND SOCIAL EMPHASIS ON THE PROVISION OF CARE IN NONINSTITUTIONAL SETTINGS. WITH MORE SERVICES BEING PROVIDED IN OUTPATIENT SETTINGS, WE HAVE GIVEN HIGH PRIORITY TO ASSURING THAT CARE MEETS HIGH STANDARDS FOR QUALITY. I WOULD LIKE TO BRIEFLY SUMMARIZE OUR QUALITY ASSURANCE ACTIVITIES FOR HOME HEALTH SERVICES.

SURVEY AND CERTIFICATION

A HOME HEALTH AGENCY MUST MEET SPECIFIC REQUIREMENTS, OR CONDITIONS OF PARTICIPATION, TO QUALIFY AS A PROVIDER OF CARE FOR MEDICARE OR MEDICAID PATIENTS. THESE CONDITIONS WERE DEVELOPED IN COOPERATION WITH PROFESSIONAL ORGANIZATIONS AND PRESCRIBE SPECIFIC REQUIREMENTS NECESSARY TO ENSURE THE HEALTH

AND SAFETY OF INDIVIDUALS RECEIVING SERVICES IN THEIR HOMES. THE CONDITIONS COVER THREE AREAS: PERSONNEL REQUIREMENTS FOR THOSE GIVING CARE, ADMINISTRATIVE REQUIREMENTS FOR AN AGENCY TO EFFECTIVELY RENDER CARE, AND REQUIREMENTS WHICH ADDRESS THE PROVISIONS OF SPECIFIC TYPES OF CARE.

WE DETERMINE WHETHER HOME HEALTH AGENCIES MEET THESE REQUIREMENTS THROUGH SURVEYS PERFORMED BY STATE AGENCIES, USUALLY STATE HEALTH DEPARTMENTS. WE SUPERVISE THE PROCESS CENTRALLY AND ISSUE NATIONAL GUIDELINES TO ASSIST SURVEYORS IN APPLYING THE CONDITIONS OF PARTICIPATION TO HOME HEALTH AGENCIES. VISITS TO PATIENTS IN THEIR HOMES IS ANOTHER ASPECT OF OUR SURVEY PROCESS INTENDED TO INSURE THAT SERVICES MEET QUALITY STANDARDS.

THE STATUTE AUTHORIZES THE SECRETARY TO DEEM THAT PROVIDERS MEET THE MEDICARE CONDITIONS OF PARTICIPATION IF THEY ARE RECOGNIZED BY AN ACCREDITING BODY AS MEETING COMPARABLE REQUIREMENTS. WE EXPECT TO ISSUE REGULATIONS SHORTLY THAT WILL PROPOSE A DEEMING PROCESS FOR HOME HEALTH AGENCIES.

THE SURVEY AND CERTIFICATION PROCESS IS AN IMPORTANT CORNERSTONE OF OUR QUALITY ASSURANCE AND SERVICE DELIVERY PROCESS AND WILL CONTINUE TO HAVE OUR STRONG SUPPORT. AS EVIDENCE OF OUR BELIEF IN THE EFFECTIVENESS OF THIS PROCESS, WE HAVE INCREASED OUR HOME HEALTH SURVEY BUDGET FOR FY 1988 BY 48 PERCENT. OVER $3 MILLION IN ADDITIONAL FUNDING WILL PERMIT US TO INCREASE THE FREQUENCY

OF HOME HEALTH AGENCY SURVEYS, PARTICULARY IN THOSE AGENCIES IN WHICH SERIOUS DEFICIENCIES HAVE BEEN FOUND.

WE ARE ALSO CHANGING THE EMPHASIS OF OUR SURVEYS TO FOCUS ON THE OUTCOMES OF PATIENT CARE RATHER THAN ON PAPERWORK. TO THIS END, WE ARE NOW DEVELOPING, UNDER CONTRACT, A PATIENT OUTCOME ORIENTED SURVEY INSTRUMENT WHICH WILL ENABLE US TO ASSESS MORE EFFECTIVELY THE ACTUAL QUALITY OF SERVICES PROVIDED IN THE HOME. IN THE FUTURE, WE EXPECT TO IMPLEMENT AN OUTCOME ORIENTED SURVEY OF HOME HEALTH AGENCIES.

OTHER REVIEW MECHANISMS

WE ALSO RELY ON OTHER MECHANISMS TO REVIEW CARE BEING PROVIDED BY HOME HEALTH AGENCIES. OUR MEDICAL REVIEW PROGRAM ASSURES THAT PAYMENT IS MADE ONLY FOR MEDICALLY NECESSARY AND APPROPRIATE CARE. UNDER THIS PROGRAM, A SAMPLE OF MEDICARE CLAIMS IS REVIEWED BY NURSES AND PHYSICIANS TO DETERMINE IF THE SERVICES WERE MEDICALLY NECESSARY AND APPROPRIATE.

FINALLY, IN ACCORDANCE WITH RECENT LEGISLATION, ALL MEDICARE PEER REVIEW ORGANIZATIONS (PROs) WILL REVIEW POST-HOSPITAL CARE, INCLUDING HOME HEALTH SERVICES, OCCURRING BETWEEN A HOSPITAL DISCHARGE AND READMISSION WITHIN LESS THAN 31 DAYS. BECAUSE THE LAW IS EFFECTIVE FOR PRO CONTRACTS RENEWED ON OR AFTER JANUARY 1, 1987, THE FIRST PRO TO IMPLEMENT THIS REVIEW IS PENNSYLVANIA. PRO REVIEW OF THESE HEALTH SERVICES IN NEW ENGLAND WILL BEGIN IN 1988.

IMPROVED ADMINISTRATION

LET ME MOVE NOW TO DISCUSS OUR EFFORTS TO ENSURE THAT MEDICARE BENEFICIARIES IN NEW ENGLAND AND THE REST OF THE NATION RECEIVE COVERAGE OF ALL THE HOME HEALTH SERVICES TO WHICH THEY ARE ENTITLED BY LAW. UNFORTUNATELY, THERE IS A PERCEPTION THAT THIS DEPARTMENT HAS A POLICY OF ENCOURAGING THE DENIAL OF CLAIMS FOR HOME HEALTH SERVICES. OF COURSE, THIS IS NOT TRUE. THIS DEPARTMENT IS COMMITTED TO ENSURING THAT MEDICARE BENEFICIARIES RECEIVE COVERAGE OF ALL HOME HEALTH SERVICES TO WHICH THEY ARE ENTITLED BY LAW.

HOWEVER, STUDIES PERFORMED BY THE GENERAL ACCOUNTING OFFICE AND BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) SEVERAL YEARS AGO INDICATED THAT UP TO A THIRD OF THE HOME HEALTH SERVICES PAID FOR UNDER THE MEDICARE PROGRAM WERE NOT COVERED BY THE PROGRAM. IN RESPONSE, IN 1985, HCFA DEVELOPED MORE COMPLETE AND UNIFORM REPORTING REQUIREMENTS FOR HOME HEALTH AGENCIES SO THAT INTERMEDIARIES COULD MORE ACCURATELY DETERMINE IF THE CARE PROVIDED WAS COVERED UNDER MEDICARE CRITERIA. AS A RESULT OF THE IMPLEMENTATION OF THE HOME HEALTH DATA FORMS, ALONG WITH INCREASED FUNDING FOR MEDICAL REVIEW AND OVERSIGHT OF QUALITY OF REVIEW DECISIONS, THE ABILITY OF FISCAL INTERMEDIARIES TO DETECT AND DENY NONCOVERED CARE HAS INCREASED SIGNIFICANTLY.

THE DENIAL RATE FOR HOME HEALTH CLAIMS IN THE BOSTON REGION AS OF SEPTEMBER 1987 WAS 6.2 PERCENT, COMPARED WITH A NATIONAL AVERAGE OF 6.8 PERCENT. FOR MAINE HOME HEALTH AGENCIES, THE DENIAL RATE FOR THIS PERIOD WAS .29 PERCENT. FURTHERMORE, 4.0 PERCENT OF THE CLAIMS IN THIS REGION, ALTHOUGH DENIED, WERE PAID FOR BY MEDICARE UNDER WAIVER OF LIABILITY. DENIAL OF A CLAIM FOR PAYMENT DOES NOT MEAN THAT A BENEFICIARY SUFFERS THE FINANCIAL HARDSHIP ASSOCIATED WITH THE DENIAL OF THE BENEFIT. UNDER THE WAIVER OF LIABILITY PROVISION, A BENEFICIARY WITH NO KNOWLEDGE THAT THE SERVICES WOULD NOT BE COVERED UNDER MEDICARE IS NOT LIABLE FOR PAYMENT IF A CLAIM IS DENIED. THUS, ONLY A VERY SMALL PERCENTAGE OF DENIALS RESULT IN OUT-OF-POCKET EXPENDITURES FOR MEDICARE BENEFICIARIES.

THE WAIVER OF LIABILITY ALSO PROTECTS PROVIDERS WHICH HAVE DEMONSTRATED THE ABILITY TO MAKE ACCURATE MEDICARE COVERAGE DECISIONS. THOSE PROVIDERS MAY BE PAID UNDER THE WAIVER FOR CLAIMS DENIED BY THE INTERMEDIARY. TO QUALIFY FOR SUCH PAYMENTS, HOME HEALTH AGENCIES ARE REQUIRED TO MEET A DENIAL RATE THAT DOES NOT EXCEED 2.5 PERCENT. IT IS TRUE THAT IN THE PAST MANY HOME HEALTH AGENCIES IN THIS REGION WERE NOT ABLE TO ACHIEVE THIS PERCENTAGE. HOWEVER, OUR MOST RECENT STATISTICS SHOW A SIGNIFICANT INCREASE IN THE NUMBER OF AGENCIES THAT HAVE ACHIEVED THE 2.5 PERCENT DENIAL RATE. WE BELIEVE THIS INCREASE RESULTS IN PART FROM A BETTER UNDERSTANDING OF MEDICARE COVERAGE REQUIREMENTS AND IMPROVED DOCUMENTATION OF SERVICES PROVIDED BY THE HOME HEALTH AGENCIES. IN ADDITION, HCFA HAS RECENTLY

MODIFIED ITS METHODOLOGY FOR CALCULATING WAIVER STATISTICS TO MORE ACCURATELY REFLECT PROVIDERS' DENIAL RATES. THIS MODIFICATION HAS ALSO CONTRIBUTED TO THE INCREASED NUMBER OF PROVIDERS WHICH QUALIFY FOR PAYMENTS UNDER THE WAIVER.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RECOGNIZES THAT THE NEWLY DISCHARGED MEDICARE PATIENT OFTEN HAS A GREATER NEED FOR HOME HEALTH CARE THAN HAS BEEN TRUE IN THE PAST. WE PLAN ON PUBLISHING REGULATIONS WHICH WOULD IMPOSE EXPLICIT DISCHARGE PLANNING REQUIREMENTS ON HOSPITALS AND HOME HEALTH AGENCIES TO ASSURE THAT PATIENTS ARE AWARE OF THE SERVICES THEY NEED AND THE SOURCES WHERE THEY MAY BE OBTAINED.

AS A DEPARTMENT COMMITTED TO MAINTAINING A HIGH LEVEL OF CARE FOR MEDICARE BENEFICIARIES, WE HAVE ALSO DEVELOPED A NATIONWIDE ACTION PLAN TO CORRECT ANY MISCONCEPTIONS ABOUT THE HOME HEALTH BENEFIT AND TO ENSURE THAT ACCURATE, CONSISTENT AND PROMPT DECISIONS ARE MADE ON HOME HEALTH CLAIMS. SPECIFICALLY,

- WE HAVE INTENSIFIED EFFORTS TO COMMUNICATE WITH MEDICARE CONTRACTORS ON HOME HEALTH AND ARE SCHEDULING REGULAR MEETINGS WITH THE INTERMEDIARIES AND REPRESENTATIVES OF THE HOME HEALTH INDUSTRY AND CONSUMER GROUPS, TO ENSURE UNIFORM UNDERSTANDING AND APPLICATION OF OUR POLICY.

- WE HAVE CONSOLIDATED THE NUMBER OF FISCAL INTERMEDIARIES THAT PROCESS HOME HEALTH CLAIMS FROM 47 TO 10.

- O WE HAVE DEVELOPED NEW TRAINING FOR INTERMEDIARIES AND HOME HEALTH AGENCIES ON PROPER CLAIMS AND ACCURATE DECISIONS, INCLUDING VIDEOTAPES EXPLAINING CURRENT COVERAGE POLICIES.

- O WE HAVE ALSO IMPLEMENTED A PILOT "CONCURRENT AUTHORIZATION" PROGRAM UNDER WHICH INTERMEDIARIES REVIEWED AND DECIDED HOME HEALTH CLAIMS SHORTLY AFTER THE ONSET OF SERVICES RATHER THAN RETROACTIVELY, IN ORDER TO PROVIDE GREATER FINANCIAL PROTECTION TO BOTH THE HOME HEALTH AGENCY AND BENEFICIARIES. THIS PILOT PROGRAM WAS CONDUCTED AT TWO SITES FOR A 90 DAY PERIOD WHICH ENDED SEPTEMBER 30, 1987. AFTER THE TWO INTERMEDIARIES INVOLVED HAVE SUBMITTED ALL DATA REGARDING THE PROGRAM, WE WILL ISSUE A REPORT OF OUR FINDINGS.

CONCLUSION

WE BELIEVE THAT THE MEDICARE HOME HEALTH BENEFIT CONTINUES TO FULFILL THE NEED ORIGINALLY INTENDED BY CONGRESS. HOWEVER, WE RECOGNIZE THAT THE AGING OF OUR POPULATION AND THE DYNAMIC CHANGES NOW OCCURRING IN OUR HEALTH CARE SYSTEM WILL CALL FOR INNOVATIVE MANAGEMENT OF HEALTH RESOURCES TO MEET FUTURE NEEDS.

IN THE LONG RUN, WE BELIEVE INCREASED USE OF THE PRIVATE HEALTH PLAN OPTIONS CAN EFFICIENTLY PROVIDE A BROAD RANGE OF MANAGED CARE OFTEN INCLUDING MORE BENEFITS THAN THE TRADITIONAL MEDICARE PACKAGE AT THE SAME OR SLIGHTLY INCREASED COST. OVERALL, WE CONTINUE TO BELIEVE THAT IT IS IN THE INTERESTS OF PATIENTS AND PROVIDERS FOR MEDICARE TO DELEGATE DECISIONS ABOUT SERVICE DELIVERY AND PRICE TO REPUTABLE FIRMS. INCREASING OPPORTUNITIES FOR MEDICARE BENEFICIARIES TO SELECT PRIVATE HEALTH PLAN OPTIONS WILL CONTINUE TO SHARE PRIORITY ON THE ADMINISTRATION'S AGENDA WITH OUR EFFORTS TO ASSURE THAT CARE MEETS THE HIGHEST STANDARDS FOR QUALITY.

I WOULD BE HAPPY TO ANSWER YOUR QUESTIONS.

VERMONT ASSEMBLY OF HOME HEALTH AGENCIES, INC.
148 MAIN STREET — TEL (802) 229-0579
MONTPELIER, VERMONT 05602

TO: Senate Special Committee

FROM: Peter Cobb, Executive Director, VAHHA

RE: Medicare

DATE: November 16, 1987

The change to Blue Cross of Maine as the Medicare Fiscal Intermediary for 16 of Vermont's 18 home health agencies, has shaken the financial foundation of the industry and left agency officials wondering how long they can keep their doors open. Increased denials, resulting in higher costs and terrible cash flow problems, has made meeting the weekly payroll an unexpected adventure. For many, only generous contributions from the towns and individuals have kept the home care professionals on the road.

Vermont is totally a not-for-profit home care state. All 18 agencies serve anyone who needs care, regardless of their ability to pay. Most have been in business a long time, and several considerably longer than Medicare itself. These are not fly-by-night agencies trying to get fat at the federal trough. They are agencies dedicated to serving all those who need help.

This care giving tradition could end if the denials continue at the pace set during the first six months of this year, when Maine rejected nearly five percent of the Vermont claims submitted. Home care is extremely cash-flow sensitive. Getting paid late or not at all for services which have already been given is not a minor irritation merely remedied on a future balance sheet. No cash for too long could push some agencies belly-up and leave Vermonters who need care with no one there.

WHAT'S HAPPENED

Medicare has rejected more home health claims this year than anytime before. For some Vermont agencies, more claims were denied last January through June than had been rejected, in total, the five years before or more. The Rutland Area Visiting Nurse Association saw its denials jump from 38 January through June 1986, to 376 the same six months this year. Community Health in White River got 127 denials through June this year compared to only 22 in 1986. Visits denied at the Central Vermont Home Health Agency jumped from six to 92.

Five of the seven agencies with Maine since January got 707 denials in the first six months of this year for a total loss of $23,925.95. Since these agencies comprise about thirty percent of the Vermont home care business, the total loss projected over twelve months for all 18 agencies could be $170,000 to $200,000.

Medicare Denials - 1986-1987

	January-June 30 1986	January-June 30 1987	
Total Claims Submitted	3,056	2,664	
Total Visits Billed	17,984	16,637	
Patients Denied	21	182	(n=five agencies)
Visits Denied	75	707	
Amount Denied	$2,218.65	$23,925.95	

NO CHANGES

The Medicare law has not changed. What has changed is how Blue Cross of Maine, the fiscal intermediary which runs Medicare in New England, is interpreting Medicare regulations. Even though there have been no substantive written regulatory changes in the Medicare home care benefit and few working changes in the Home Health Coverage Manual in the last five years, Vermont agencies are getting frequent payment denials for services which had been routinely covered.

THE PROBLEM

The first problem is patient care-- constant denials force home health staff to choose between giving the care needed and providing only that which Medicare will pay. The physicians and nurses who develop patient care plans are being second-guessed by office staff who have never seen the patient, do not know his home environment, and may not fully understand home care.

The second problem is money-- denials cost money and decrease agency income. Several agencies have had to hire staff just to process appeals and double check bills. Increased paperwork also drops the nurses' productivity so that she visits fewer patients per week, which further decreases agency income. Meanwhile most home health agencies are near or above the Medicare cap and some have passed the Medicare cost limit. Agency directors report the administrative cost to run the Medicare program is 30% or more of their total service cost. One agency had its cost for a nursing visit jump from $42 in January, to over $50 last month, most of the increase resulting from costs incurred from added denials.

In addition, increased denials result in less cash on hand to meet payroll and pay other important bills. Before January all 18 Vermont agencies were "on-waiver" where Medicare paid all disputed claims. On-waiver is when Medicare rejects 2.5% or less of the home care bills submitted but pays all claims anyway. When Medicare rejects more than 2.5% for a quarter, it stops paying all denied claims. All seven Vermont agencies which switched to Maine in January were "off waiver" in July. (Several have regained their favorable status.)

Based on the first six months, these denials could result in a $200,000 loss next year to Vermont home health agencies. Much of the money will be returned through appeal but that can take anywhere from six months to two years.

All this comes at a time when the traditional sources of outside income, town funds and donations, are getting more tight. Last year Congress ended Revenue Sharing, which had been a major home care income source. Getting needed town money is more difficult now than ever before. Also, private donors are being asked to give more to more agencies, which makes the private dollar more difficult to secure.

Medicare Denial Data/Blue Cross of Maine
For Vermont, January - June, 1987

Seven agencies participated January - February (100%), five agencies March - June (72%).

	Jan/Feb	March/June	Total
Claims Submitted:	1,055	1,498	2,553
Total Visits Billed:	5,439	9,861	15,300
Number Patients Denied:	68(6.4%)	123(8.2%)	191(7.5%)
Visits Denied by Discipline			
RN	189	249	438
PT (Physical Therapy)	44	78	122
OT (Occupational Therapy)	-	12	12
ST (Speech Therapy)	-	-	-
MSW (Social Work)	-	-	-
HHA (Aide)	113	51	165
Total	346(6.4%)	390(4.0%)	737(4.8%)
Amount Denied by Discipline:			
RN	7,819	9,649	17,648
PT	1,634.50	2,426.25	4,060.75
OT	-	474	474
ST	-	-	-
MSW	-	-	-
HHA	2,447.51	840	3,287.51
Total	11,910.01	13,389.25	25,290.26
Visits Submitted for Reopening	191	159	342
Denials Reversed	-	21	21
Percent Denial	6.4%	3.7%	4.7%

SOME SOLUTIONS

Among the actions which could help are:

1. Eliminate all review criteria which are really smokescreens for cost cutting such as the five to one ratio where the fiscal intermediary is expected to recover five dollars for every dollar spent in medical review. The goal of medical review should be to eliminate unnecessary care and assure quality service,and not to cut costs.
2. Cut the paperwork. At present, the administrative cost to run the Medicare program for most Vermont agencies runs 30 percent or more. This is ridiculous. HCFA is constantly whining that home care is the fastest growing sector of the health care budget. How much of this is due to increased costs which have been forced on the industry?
3. Develop a true long term care system. The federal government needs to recognize that home care is part of the total health care system and not just a distant relative that nobody knows or cares about.

Several bills have been introduced which could help including:

1. S. 1616, The Medicare Long-Term Care Benefit for Elderly, Disabled and Children

   This bill addresses the fact that 80 percent of catastrophic health care expenses are for long-term care provided outside of hospitals. It eliminates the "intermittent" part-time and "skilled nursing" requirements from the Medicare home care rules thus providing coverage for a less intensive level of care than is now covered. Elderly Medicare clients would receive services if a physician certifies a person needs help in performing two or more of the activities of daily living, or has a similar level of dependency due to cognitive impairment. Chronically ill or technology-dependent children would be included in the Medicare definition of "disabled."

   The estimated annual cost of $6 billion would be paid by extending the Social Security tax to the first $100,000 of an individual's annual earnings.

2. S. 1076, The Medicare Home Health Services Improvement Act

   This bill would require fiscal intermediaries to provide adequate explanations of claims denials; require that reconsiderations be processed within 60 days or interest be paid to the provider; require the Health Care Financing Administration to comply with the Administrative Procedures Act and require standards for training home care paraprofessionals.

KENT COUNTY VISITING NURSE ASSOCIATION

TESTIMONY PREPARED BY CLAIRE S. CONNOR, EXECUTIVE DIRECTOR, KENT COUNTY VISITING NURSE ASSOCIATION, WARWICK, RHODE ISLAND FOR THE SENATOR MITCHELL/SENATOR COHEN HEARING ON THE MEDICARE DENIAL CRISIS:

The ongoing re-interpretations of Medicare Guidelines by Blue Cross of Maine has had a serious impact on the overall operations of Kent County VNA.

Denials of care present problems on several levels, the most immediate one being clinical in nature. It appears that we have entered an era in which the determination of patient care is no longer the province of the physician who orders it, or the community health nurse who administers and assesses it; but rather it is the sole right of the third party - i.e., the Medicare fiscal intermediary who reviews it without benefit of having been witness to the patient's progress or lack of it.

This review process has resulted in a 30% decline in Medicare visits over the past several months. In conjunction with the drop in visits, there has been a corresponding decline in the number of clients referred to the Medicare Program. What is happening to these patients? I can only surmise that hospital discharge planners are not making referrals because of the high probability of services not being covered - or worse yet, patients are not requesting the home health services which they are entitled to under the Medicare Program because they are afraid they will be responsible for payment.

The financial implications of this rationing of care by Medicare are grave, as well. The percentage of free visits made in 1987 by KCVNA has almost doubled; the Medicaid visits have increased by 15%. The fiscal viability of the Agency has to be threatened with the increased financial burdents of unreimbursed care.

In addition, the administrative costs of fighting denials is high - and as patient advocates, that is our responsibility: to challenge denials! A conservative estimate for the first nine months of 1987 is $25,000, which could have been used to underwrite 500 free visits or to underwrite our Geriatric Maintenance Program or to sponsor, county-wide, free clinics!

The fiscal intermediary cannot be allowed to continue the practice of denying care which is deemed medically necessary by the professional personnel who are actually involved in the patient's treatment. Home health agencies such as represented at this hearing need immediate relief from this dilemma, so that we may spend all our time, energies and resources on what we do best - care for the ill and needy of the community.

Claire S. Connor

Claire S. Connor, R.N., M.P.H.
Executive Director
November 16, 1987

TESTIMONY
TO THE
MEMBERS OF THE SENATE FINANCE COMMITTEE

I want to thank you for the opportunity to present testimony today, November 16, 1987, on the critical problem of denials for payment of Home Health Services to Medicare patients.

I represent the Visiting Nurse Association of Boston, the oldest and second largest Visiting Nurse Association in the country. We have been in existence for over 100 years. Currently, we provide about 500,000 patient visits to 11,000 residents in the city of Boston and several surrounding communities. We utilize over 600 nurses, therapists, and home health aides to provide these services.

Even though we are an established and sizeable organization, the Visiting Nurse Association of Boston is experiencing significant financial consequences as a result of the Medicare denials.

FINANCIAL LOSS

Our denial rates with Maine Blue Cross have been 13.65% and 10.27%, a dramatic increase from the 2.67% we had when we transferred from Mass. Blue Cross. It is important to note that our understanding of the coverage issues and our documentation has been better, not worse, yet denials for payment have increased. Our denial rate means that over 1,000 patient visits or over $50,000 of payments have been denied to the Visiting Nurse Association of Boston each month.

We are a large agency, but as we are reimbursed on a cost basis, we do not have the "cushion" necessary to absorb a probable $600,000 loss in payments this year.

LACK OF GUIDELINES

A major factor which has contributed to the denials has been the unavailability of clear coverage guidelines. We do not know prior to servicing a patient what will actually be covered and what will be denied.

Educational sessions given by the Fiscal Intermediary have been infrequent and resulted in confusion, not clarification. Definitions of daily visits, the number of visits per diagnosis, the justification for visits twice a day, and guidelines for skilled assessment are examples of needed clarifications which have been difficult to obtain.

There has been a major change in the reasons given for denials for payment. Previously, at least 60 % of our denials were for "technical" reasons, now only 1 - 2 % of our denials are for these reasons.

We have best learned the F.I.'s coverage interpretations by monitoring what is denied. However, as denials are received several months after the service has been provided, all similar visits during that several month time frame can also be expected to be denied.

What may initially appear to be a trend in coverage based on denials may not prove to be so as 25 - 40% of denials become overturned and approved for payment on reopening. The situation has become confusing and service is provided based on the best "guess" of what will be covered.

Very often we have been told that our documentation was not adequate when we questioned a denial. However, requests for examples of good documentation have yielded examples similar to ours which were denied. One specific case of ours was identified by the F.I. as an example of excellent documentation; this, however, was after this same documentation had been twice denied by them.

ADDITIONAL COSTS

We certainly recognize the need to control costs; however, the current system has required us to increase our costs significantly.

Additional staff have been hired solely to appeal and monitor Medicare denials and to educate staff about the documentation requirements. We will spend over $130,000 this year for these additonal positions and still not have in place the numbers of people we should have to cope with this problem.

A second less obvious but equally concerning increase in our costs is from the addditional documentation required. Nurses must almost duplicate the clinical record documentation on the HCFA forms, thereby doubling their documentation time. Further documentation must be provided for requests for "clarification" and for the appeals process.

At a time when we are facing a significant nursing shortage, it is of concern to hear with increasing frequency that nurses are leaving home care, not because they do not like providing the care, but because of excessive paperwork and constant negative feedback in the form of Medicare denials.

SUMMARY

I know of no other health care area subject to the vagueness and arbitrariness applied to the coverage of home care services under Medicare.

Home Health Agencies need to be given clearly stated, objective coverage guidelines from which to operate. The subjective and arbitrary interpretation of the guidelines has become too costly for continued use.

Especially concerning is the fact that coverage guidelines were lacking from the Fiscal Intermediary until 1987 denials were received in May and June, after half a year's worth of service had been provided. Without any notification that services and documentation should be adjusted, how could agencies know what to change. It is unreasonable to require agencies to repay money they do not have because guidelines limiting services were not made available to them.

The end result, of course, will be decreased services available to patients. Services are be limited based on denial experience, free care dollars are being drawn away from other patients, and nurses are leaving the field.

The Medicare denials must be stopped until complete identification of guidelines and interpretation is provided. The denials in 1987 must not be charged to the home health agencies. We cannot afford to continue to "guess" about the reimbursable home health services under Medicare.

Testimony submitted by

Carol Crawford

Carol Crawford, R.N.,M.S.N.
Director of Patient Services
Visiting Nurse Association of Boston

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TESTIMONY TO SENATOR MITCHELL

Hearing on Medicare Denial Crisis
Portland, Maine
November 16, 1987

My name is Robin Gallup, Executive Director of Lake Sunapee Home Health Care in New London, New Hampshire. I am here to represent residents of rural New Hampshire who are in need of home health care. The isolated, sick, and disabled elderly in rural New Hampshire need visiting nurses.

Many of these people are in their late 80's and 90's and with the help of the visiting nurses are able to remain living independently in their own homes. Medicare denials are jeopardizing their health and safety, and ultimately their ability to remain out of the hospital or nursing home.

The following is an example:

Mr. Newton is 80 years old and was discharged from the hospital to home care with gangrene of his left foot. He has no indoor plumbing and lives alone on a hill that is often impassable in winter and mud season. The visiting nurse went every day to provide wound care and assess that his circulation was adequate to the left foot.

Medicare decided that nursing visits more than twice a week were not necessary. The patient's condition deteriorated. Within one month Mr. Newton was readmitted to the hospital where he underwent an amputation of the left leg.

It is on behalf of Mr. Newton and others like him that I urge Medicare to stop denying home health benefits. The frail elderly need visiting nurses. They need your support.

Respectfully submitted,

Robin Gallup

Robin Gallup, RN
Executive Director
Lake Sunapee Home Health Care, Inc.